



STATE OF TENNESSEE GROUP INSURANCE PROGRAM
2024 ENROLLMENT CHANGE APPLICATION
University of Tennessee Chattanooga • Office of Human Resources • Insurance Dept 3603
720 McCallie Ave • Chattanooga, TN 37403 • office 423.425.4452 • fax 423.425.4574

PART 1: ACTION REQUESTED — PLEASE SEE PAGE 3 FOR INSTRUCTIONS

TYPE OF ACTION	COVERAGE	PARTICIPANTS AFFECTED	REASON FOR THIS ACTION	QUALIFYING EVENT - review page 2, complete page 3 for medical/dental/vision	
<input type="checkbox"/> Add coverage <input type="checkbox"/> Change coverage Form not for cancellation	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Disability	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> New Hire/Newly Eligible <input type="checkbox"/> Court Order <input type="checkbox"/> Annual Enrollment Revision <input type="checkbox"/> Other _____	<input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Adoption	<input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Loss of Eligibility

PART 2: EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
SOCIAL SECURITY NUMBER	EMPLOYING AGENCY		EMPLOYER GROUP: <input type="checkbox"/> HED	YOUR CURRENT STATUS <input type="checkbox"/> Active	
HOME ADDRESS	<input type="checkbox"/> UPDATE MY ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: HEALTH COVERAGE SELECTION — CHOOSE CAREFULLY. EXCEPT FOR QUALIFYING EVENTS, CHANGES ARE NOT ALLOWED OUTSIDE THIS PLAN'S ANNUAL ENROLLMENT.

SELECT AN OPTION <input type="checkbox"/> Premier PPO <input type="checkbox"/> CDHP/HSA <input type="checkbox"/> Standard PPO	<h2>HSA</h2> <p>Please complete an HSA deduction form requested from utinsurance@tennessee.edu</p>	SELECT A CARRIER & NETWORK <input type="checkbox"/> BCBS Network S <input type="checkbox"/> BCBS Network P* <input type="checkbox"/> Cigna LocalPlus <input type="checkbox"/> Cigna Open Access* *higher premium applies	SELECT A HEALTH PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)
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PART 4: DENTAL COVERAGE SELECTION

SELECT A PLAN	SELECT A DENTAL PREMIUM LEVEL
<input type="checkbox"/> Delta Dental DPPO <input type="checkbox"/> Cigna DHMO (Prepaid Provider)	<input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)

PART 5: VISION COVERAGE SELECTION

SELECT A PLAN	SELECT A VISION PREMIUM LEVEL
<input type="checkbox"/> Basic Plan <input type="checkbox"/> Expanded Plan	<input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)

PART 6: DISABILITY SELECTION (ST/UT/TBR)

SHORT TERM DISABILITY	LONG TERM DISABILITY
<input type="checkbox"/> 60%/14 day Elimination Period <input type="checkbox"/> 60%/30 day Elimination Period	<input type="checkbox"/> Employer pays prem - 63%/90 day Elim Period <input type="checkbox"/> Employee pay - 60%/90 day Elim Period <input type="checkbox"/> Employee pay - 60%/180 day Elim Period <input type="checkbox"/> Employee pay - 63%/180 day Elim Period

PART 7: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE *	SOCIAL SECURITY NUMBER	HEALTH	DENTAL	VISION
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*The acquire date is the date of marriage, birth, adoption or guardianship. Proof of a dependent's eligibility must be submitted with this application for all new dependents (see page 2). A separate sheet with more dependents is attached

PART 8: EMPLOYEE AUTHORIZATION

Accept I confirm that the information above is true. I understand my health, dental and vision selections are effective until the end of the plan year (December 31) subject to plan eligibility criteria, and that I cannot change insurance plans or carriers during the plan year. If I experience a qualifying event, I may be eligible for changes in enrollment of plan members and dependents (see pg 3). I understand that submission of fraudulent information may lead to consequences including cancellation of insurance, disciplinary action from my employer, or possible criminal penalties. I understand that if my dependent loses eligibility, it is my responsibility to notify my benefits coordinator, and coverage will terminate at the end of the month in which the loss of eligibility occurs. I understand that I will be held responsible for any claims paid in error if I fail to notify.

Refuse I have been given the opportunity by my employer to apply for the group insurance program and have decided not to take advantage of this offer. I understand that if I later wish to apply, I or my dependents will have to provide proof of a qualifying event or wait until annual enrollment.

EMPLOYEE SIGNATURE	DATE	HOME PHONE (REQUIRED)	EMAIL ADDRESS (REQUIRED)
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AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR

ORIGINAL HIRE DATE	COVERAGE BEGIN DATE	POSITION NUMBER	EDISON ID	NOTES TO BENEFITS ADMINISTRATION <input type="checkbox"/> PPACA Eligible <input type="checkbox"/> 1450 Eligible
AGENCY BENEFITS COORDINATOR SIGNATURE			DATE	

Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send to Benefits Administration.



DEPENDENT ELIGIBILITY

Definitions and Required Documents

**PARTNERS
FOR HEALTH**

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	You will need to provide a document proving marital relationship AND one document from the additional documents list below:
		Proof of Marital Relationship <ul style="list-style-type: none"> • Government-issued marriage certificate or license • Naturalization papers indicating marital status
		Additional Documents <ul style="list-style-type: none"> • Bank Statement issued within the last six months with both names; or • Mortgage Statement issued within the last six months with both names; or • Residential Lease Agreement within the current terms with both names; or • Credit Card Statement issued within the last six months with both names; or • Property Tax Statement issued within the last 12 months with both names; or • The first page of most recent Federal Tax Return filed showing “married filing jointly” or “married filing separately” with the name of the spouse provided thereon; submit page 1 of the return with the income figures blacked out
		If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child’s birth certificate (will accept mother’s copy for newborn); or
		Certificate of Report of Birth (DS-1350); or
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or
		Certification of Birth Abroad (FS-545)
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	Final court order granting adoption; or
		International adoption papers from country of adoption; or
		Court order placing child in custody of member for purpose of adoption
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse, or documents determined by BA to be the legal equivalent
Disabled dependent	A dependent of any age who falls under one of the child categories previously listed and due to a mental or physical disability, is unable to earn a living. The dependent’s disability must have begun before age 26 and while covered under a state-sponsored plan.	<p>Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent’s 26th birthday. Additional documentation will be required to comply with any future review.</p> <p>The insurance carrier will review the form, make a determination and provide BA with documentation once a determination has been made. If approved for incapacity, the child will continue the same coverage.</p>
Child under age 26 placed for guardianship, custody or conservatorship with the head of contract* (placement order active or expired due to age of majority)	A child under age 26 for whom the head of contract is or has been the legal guardian, custodian or conservator	Valid order by a court of competent jurisdiction (placement order) establishing guardianship, custody or conservatorship arrangement between child and head of contract; and an attestation signed by the head of contract upon initial enrollment and upon request

*Head of contract is the person who elects coverage and has authority to change coverage elections.

Never send original documents. Please mark out or black out any Social Security numbers and any personal financial information on the copies of your documents BEFORE you return them.

NAME	EDISON ID	OR	SSN
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Qualifying Events

If you or a dependent lose coverage under any other group insurance plan, or if you acquire a new dependent during the plan year, the federal Health Insurance Portability and Accountability Act (HIPAA) may provide additional opportunities for you and eligible dependents to enroll in health coverage. If you are adding dependents to your **existing** coverage, you and eligible dependents may transfer to a different carrier or healthcare option, if eligible. You or eligible dependents may also be eligible to enroll in dental and vision coverage if you meet the requirements stated in the dental or vision certificates of coverage. Premiums are not prorated. If approved, you must pay the required premium for the entire month in which the effective date occurs.

INSTRUCTIONS: Identify the qualifying event(s) which applies to you or your eligible dependent(s). You must submit this page with the appropriate required documentation, proof of prior coverage and a completed enrollment application.

NOTE: Application for enrollment must be made within 60 days of the loss of eligibility for other health insurance coverage or within 30 days of a new dependent's acquire date. Voluntary actions resulting in loss of coverage (such as voluntary cancellation of coverage and cancellation for not paying premiums) ARE NOT qualifying events. Electing to cancel, waive or decline coverage during another plan's enrollment period IS NOT a qualifying event.

Retroactive coverage (a coverage effective date that begins before an enrollment is completed and submitted to BA) **is not allowed except for birth, adoption and placement for adoption.** For all other events, the earliest effective date allowed for coverage under this plan is the first day of the month following the date that your enrollment request, including all required documentation, is completed and submitted to BA. Enrollment should be completed and submitted to BA as soon as possible to ensure the earliest possible effective date. The examples provided below assume all eligibility requirements are satisfied and that required documentation is submitted with enrollment.

EXAMPLE 1	EXAMPLE 2
<p>Marriage date is June 15 (30- day enrollment period applies):</p> <ul style="list-style-type: none"> enrollment submitted to BA on June 25 = 7/1 effective date enrollment submitted to BA on July 10 = 8/1 effective date enrollment submitted on or after July 16 will exceed the 30-day enrollment period, and your request will be denied 	<p>Loss of other coverage date is June 30 (60-day enrollment period applies):</p> <ul style="list-style-type: none"> enrollment submitted to BA on June 30 = 7/1 effective date enrollment submitted to BA on July 10 = 8/1 effective date enrollment submitted to BA on August 5 = 9/1 effective date enrollment submitted on or after August 30 will exceed the 60-day enrollment period, and your request will be denied

QUALIFYING EVENT	EFFECTIVE DATE	DOCUMENTATION REQUIRED
<input type="checkbox"/> An event causing the loss of eligibility for coverage from another group health insurance plan*	The effective date is the first day of the first calendar month after the date BA receives the request for special enrollment	Written documentation from an employer, former employer, insurance company, or former insurance company on company letterhead that lists (1) names of covered participants; (2) dates of coverage including your coverage at the time coverage in this plan was declined; (3) types of coverage (medical, dental, vision); (4) each participant that lost eligibility for coverage; (5) the date of loss of eligibility to continue coverage, and (6) the reason why eligibility for coverage was lost
<input type="checkbox"/> An event that results in acquisition of a new dependent spouse or stepchild acquired by marriage, or a child acquired pursuant to an order of guardianship**	The effective date is the first day of the first calendar month after the date BA receives the request for special enrollment	1. Marriage Certificate 2. Birth Certificate (will accept mother's copy for newborn) 3. Order of Guardianship requiring financial support and provision of insurance coverage, which sets out the date of the guardianship period
<input type="checkbox"/> An event that results in acquisition of a new dependent acquired by birth, adoption, or placement in legal custody for adoption**	The effective date is the date of birth, adoption, or placement for adoption	1. Birth Certificate (will accept mother's copy for newborn) 2. Final Order of Adoption or Order of Custody in anticipation of adoption

* When eligibility for coverage under other insurance is lost, only the Employee and any dependents who lose the other coverage may enroll.

** When a new dependent is acquired, an Employee may enroll in employee only or family coverage and may add the new dependent and previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible).

The employee and dependents may only enroll in the types of coverage lost (medical/medical; dental/dental; vision/vision).

INSTRUCTIONS

Please complete the entire form and do not leave anything blank. Leaving a section blank can cause a delay in processing your request.

To add or change health, dental or vision coverage during the annual enrollment period, follow these instructions for each section in Part 1:

TYPE OF ACTION — mark the box indicating that you want to add or change coverage

COVERAGE AFFECTED — mark all that apply

PARTICIPANTS AFFECTED — mark all that apply

REASON FOR THIS ACTION — indicate reason for action – if making changes during annual enrollment period mark "Other" and write in AEP

Please make sure the rest of the form is filled out completely and be sure to sign and date the form. If you are an active employee, return your completed form to your agency benefits coordinator.

