



Part 1: Action Requested					
<b>Type of Action</b> <input type="checkbox"/> Add Coverage <input type="checkbox"/> Update Personal Info	<b>Reason for Action</b> <input type="checkbox"/> New Retiree <input type="checkbox"/> Surviving Spouse Continuing Coverage	<b>Participants Affected</b> <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<b>Coverage Affected</b> <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medicare Supp	<b>Agency Retired From</b>	
				<b>Date of Retirement</b>	<b>Termination Date (see page 3)</b>

Part 2: Retiree 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	Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Medicare Part A Effective Date		Medicare Part B Effective Date	
Home Address	<input type="checkbox"/> Update my address	City	ST	ZIP Code	County

Part 3: Group Health Coverage Continuation			Part 4: Medicare Supplement Enrollment		
<b>Check all that apply</b> <input type="checkbox"/> retiree <input type="checkbox"/> spouse <input type="checkbox"/> child(ren)			<b>Check all that apply</b> <input type="checkbox"/> retiree <input type="checkbox"/> spouse <input type="checkbox"/> child(ren)		

Part 5: Dental Coverage		Part 6: Vision Coverage	
<b>Plan</b> <input type="checkbox"/> PDO <input type="checkbox"/> Prepaid	<b>Check all that apply</b> <input type="checkbox"/> retiree <input type="checkbox"/> spouse <input type="checkbox"/> child(ren)	<b>Plan</b> <input type="checkbox"/> Basic <input type="checkbox"/> Expanded	<b>Check all that apply – must be enrolled in group health</b> <input type="checkbox"/> retiree <input type="checkbox"/> spouse <input type="checkbox"/> child(ren)

Part 7: Dependent Information – attach a separate sheet if necessary					
Name (First, MI, Last)	Date of Birth	Relationship	Gender	Social Security Number	Medicare Eligible?
			<input type="checkbox"/> M <input type="checkbox"/> F		Part A <input type="checkbox"/> Y <input type="checkbox"/> N <span style="float:right">Date Effective</span>
			<input type="checkbox"/> M <input type="checkbox"/> F		Part A <input type="checkbox"/> Y <input type="checkbox"/> N <span style="float:right">Date Effective</span>
			<input type="checkbox"/> M <input type="checkbox"/> F		Part A <input type="checkbox"/> Y <input type="checkbox"/> N <span style="float:right">Date Effective</span>

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: Authorization			
I confirm that all of the information above is true. If coverage is being continued in the Partnership PPO then I agree to the terms and conditions of the Partnership Promise for the plan year indicated on page 4. I know that I can lose my insurance if I give false information. I may also face disciplinary and legal charges. If my dependents lose eligibility, I know that I must tell Benefits Administration within one calendar month. If I do not, then I will have to pay the plan back for all of my dependent's health care bills. I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents. I have read and understand the information and eligibility criteria on page three.			
Signature	Date	Home Phone	Email Address

Part 9: Employer Certification – MUST BE COMPLETED BY YOUR AGENCY					
Retiree is: <input type="checkbox"/> TCRS <input type="checkbox"/> NON-TCRS <input type="checkbox"/> ORP/TIAA <input type="checkbox"/> FRM LEGIS			Premium: <input type="checkbox"/> RET <input type="checkbox"/> INS <input type="checkbox"/> BIL		Type: <input type="checkbox"/> ST <input type="checkbox"/> LE <input type="checkbox"/> LE-SS <input type="checkbox"/> LG
Active Cvg Term Date	RET Cvg Effect Date	Years of Creditable Svc	Length of participation in the plan immediately prior to termination of employment <input type="checkbox"/> 3 OR MORE YEARS <input type="checkbox"/> 1-3 YEARS <input type="checkbox"/> LESS THAN 1 YEAR		
Name of Agency			Agency Signature	Date	Phone Number

If you will receive a TCRS benefit, submit this application with your pension application to TCRS. If you will receive an optional retirement benefit, send to Benefits Administration.

# Dependent Eligibility

## Definitions and Required Documents

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 <b>AND</b> a document proving joint ownership
		<b>Proof of Marital Relationship</b> <ul style="list-style-type: none"> <li>• Government issued marriage certificate or license</li> <li>• Naturalization papers indicating marital status</li> </ul>
		<b>Proof of Joint Ownership</b> <ul style="list-style-type: none"> <li>• Bank Statement issued within the last six months with both names; <b>or</b></li> <li>• Mortgage Statement issued within the last six months with both names; <b>or</b></li> <li>• Residential Lease Agreement within the current terms with both names; <b>or</b></li> <li>• Credit Card Statement issued within the last six months with both names; <b>or</b></li> <li>• Property Tax Statement issued within the last 12 months with both names; <b>or</b></li> <li>• The first page of most recent Federal Tax Return filed showing “married filing jointly”</li> </ul>
		If just married in the current calendar year, a marriage certificate only is acceptable proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child’s birth certificate; <b>or</b>
		Certificate of Report of Birth (DS-1350); <b>or</b>
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); <b>or</b>
		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	Court documents signed by a judge showing that the participant has adopted the child; <b>or</b>
		International adoption papers from country of adoption; <b>or</b>
		Papers from the adoption agency showing intent to adopt
Child for whom the participant is legal guardian	A child for whom the participant is the legal guardian	Any legal document that establishes guardianship
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse and birth certificate of the child showing the relationship to the spouse; <b>or</b>
		Any legal document that establishes relationship between the stepchild and the spouse or the member
Child for whom the plan has received a qualified medical child support order	A child who is named as an alternate recipient with respect to the participant under a Qualified Medical Child Support Order (QMCSO)	Court documents signed by a judge; <b>or</b>
		Medical support orders issued by a state agency
Disabled dependent	A dependent of any age (who falls under one of the 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.	Documentation will be provided by the insurance carrier at the time incapacitation is determined

**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.**

# Instructions

**Part 1:** This section should be completely filled out by the retiree and the separating agency. For TCRS members, the date of retirement is the effective date of your retirement with the Tennessee Consolidated Retirement System. The termination date of employment is either the last day in an active paid status or the last day of an approved leave of absence, whichever is later. This date must be confirmed by your separating agency and is certified by your Agency Benefit Coordinator signing the Employer Certification section on part 8 of this form.

**Part 2 RETIREE INFORMATION:** This section must be completed by the retiree. If you are a surviving spouse who is continuing coverage as the new head of contract on the retiree plan, please complete the application with your information as the retiree. If you are entitled to Medicare you must submit a copy of your Medicare card with this application.

**Part 3 GROUP HEALTH:** Eligibility requirements to continue group health coverage for retirees and their dependents are outlined in the State Plan Document. Requirements for State and Higher Education retirees can be found in Section 4.07. Local Education and Local Government retiree's eligibility requirements are outlined in Section 4.06 of the respective Plan Documents. The state plan documents can be viewed at [www.tn.gov/finance/ins/](http://www.tn.gov/finance/ins/).

I further understand per the eligibility requirements as outlined in the state plan documents, State/Higher Education section 4.06 and Local Education section 4.05 that if I am a retiree who qualifies to continue group health coverage and either myself or a covered dependent becomes entitled to Medicare Part A prior to the age of 65, the retiree and/or their covered Medicare Part A eligible dependent must enroll in Part B in order to maintain group health coverage until entitled to Medicare by virtue of age. You must submit a copy of your Medicare card to Benefits Administration as documentation you have enrolled in Part A and B. If the pre 65 Medicare entitled retiree or retiree dependent does not enroll in Medicare part B when eligible coverage under the state group health plan will be terminated.

LOCAL GOVERNMENT retirees and dependents who become entitled to Medicare Part A are **NOT** eligible for coverage under the retiree group health plan as referenced in section 4.05 of the Local Government plan document.

In all cases, it is the responsibility of the retiree to notify Benefits Administration within 5 working days if the retiree or a covered dependent has become eligible for Medicare prior to the age of 65.

**Part 4 MEDICARE SUPPLEMENT:** To be eligible for the TN Plan Medicare Supplement policy you must be receiving a monthly TCRS or Higher Education ORP retirement benefit and the retiree and/or the dependent they wish to cover must be enrolled in at least Medicare Part A. **You must submit a copy of your Medicare card with this application.** The TN Plan will not pay if you are not enrolled in Medicare. If you only enroll in Medicare Part A, the TN Plan will pay after Medicare for Part A expenses but will not pay for Medicare Part B expenses. In addition, the TN Plan will not pay behind or coordinate benefits if you have enrolled in a Medicare HMO or Medicare Advantage plan. The TN Plan does not offer any pharmacy benefits. You must enroll in Medicare Part D or subscribe to another supplemental for pharmacy needs. If you are enrolled in TennCare you do not need Medicare supplement coverage. This enrollment form must be completed within 60 days of initial eligibility which is either the date you become eligible for Medicare, your date of retirement or the effective date of loss of creditable group health coverage; whichever is later.

If you are applying 60 days or more past your initial eligibility date, you must apply as a late applicant and enrollment will be subject to approval. If you are a late applicant, please contact Benefits Administration for Medicare supplement late applicant information.

**Part 5 DENTAL:** To be eligible to apply for retiree dental you **MUST** be receiving a monthly TCRS or a Higher Education ORP benefit. If you do not apply within one full calendar month of your active group health insurance and/or dental benefits termination the effective date of your coverage will be the first of the following month in which you apply. If you select the Prepaid dental plan please note that you **MUST** select an Assurant dentist that participates in the STATE of TENNESSEE network. The Prepaid plan will not pay any benefits if you do not select a participating dentist and provide this information to Assurant. **Once your coverage has changed from active to retiree you MUST contact Assurant to confirm your continued use of your selected participating network dentist.** Additional information on retiree dental and COBRA dental can be obtained from your agency Benefits Coordinator or viewed at [www.tn.gov/finance/ins/](http://www.tn.gov/finance/ins/).

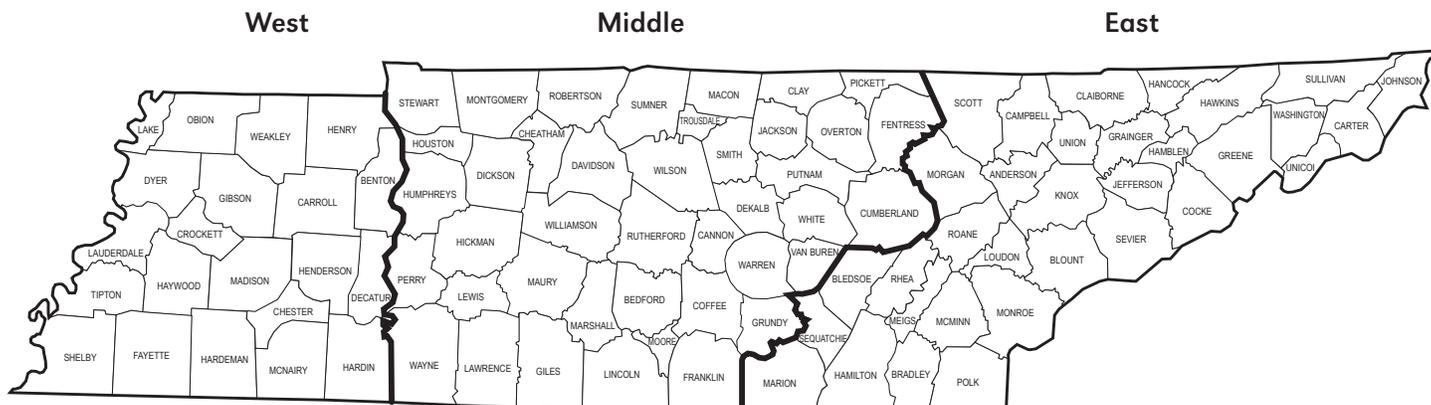
**Part 6 VISION:** To be eligible to apply for vision you **MUST** be receiving a monthly TCRS or a Higher Education ORP benefit and be enrolled in group health coverage.

**Part 7 DEPENDENT INFORMATION:** This section must be completed if you are applying to cover a dependent on any of the state insurance benefits. Please note that if you are applying to cover a dependent on retiree group health or the Medicare supplement plan, you must also complete their Medicare eligibility information in this section **and submit a copy of their Medicare card if they are Medicare entitled.** If you have not previously submitted dependent verification documentation on a dependent you are applying to cover, please submit the applicable documentation with this application as outlined on page 4.

**Part 8 RETIREE AUTHORIZATION:** This section must be signed and dated by the retiree (or surviving spouse if they are the new head of contract). If the retiree has a designated Power of Attorney, a copy of the POA must be attached to this application.

**Part 9 EMPLOYER CERTIFICATION:** The designated official with the separating agency must complete and certify if the retiree is a TCRS member, a NON TCRS retiree, a higher education Optional Retirement Plan (ORP) retiree or a Former Legislator. The correct premium collection method should also be designated. RET= premiums will be collected from the TCRS pension check, INS=Benefits Administration has agreed to bill the agency for retiree premiums, BIL = the retiree will be billed directly at home by Benefits Administration. Type of retiree must also be completed: ST = State LE= Local Ed Teacher/ certified staff LE-SS = Local Ed Support Staff and LG= Local Government. Active coverage term date indicates the date insurance as an active employee is terminate. Years of creditable service must be certified by agency for NON TCRS, ORP and Former Legislators. For TCRS members, the application should be submitted to TCRS with the pension application for years of creditable service certification. The Agency should also review and mark on the form the applicable time frame the retiree has been continuously covered on the plan immediately preceding termination of employment. The Form must be signed and dated by the designated agency official. By signing the Employer Certification section the agency is also certifying the correct Term date of employment and Date of Retirement has been completed in Part 1 of the form.

## COUNTIES AND REGIONS FOR HEALTH PLANS



Out of state residents: If you do not live in a state that borders Tennessee, select the middle region. If you live in a bordering state, select the region closest to the border.

### 2013 PARTNERSHIP PROMISE

#### Members and covered spouses must:

- Complete the online Healthways Well-Being Assessment™ (health questionnaire) **by March 15, 2013**
- Engage in one ParTNers for Health wellness activity **by July 15, 2013**
- Keep your contact information current with your employer
- Engage in the tobacco cessation program if you are a tobacco user

#### Members and covered spouses identified as at risk must also:

- Complete a biometric screening at your health care provider's office **between July 15, 2012, and July 15, 2013**
- Participate in health coaching and/or case management, if identified in 2013

New employees (as of 1/1/13) will be required to complete the online Well-Being Assessment and biometric screening within 120 days of their insurance coverage effective date.

Visit our website at [www.partnersforhealthtn.gov](http://www.partnersforhealthtn.gov) for more information about the Partnership Promise.

**Enrollment in Partnership PPO.** By choosing the Partnership PPO you, and your dependent spouse (if applicable), agree to complete the Partnership Promise requirements each year that you are enrolled in the Partnership PPO. During the Annual Enrollment Transfer Period (AETP) each year, you may select another health insurance option. If you do not do so, you will continue to be enrolled in the Partnership PPO, if eligible.

**Requirements of the Partnership PPO.** You will be informed of the requirements of the Partnership Promise on or before AETP each year. If you are unable to complete the requirements of the Partnership Promise because of a medical or mental health condition we will work with you to develop an alternative way to qualify for the Partnership PPO.

**Disenrollment from Partnership PPO.** If you, or your dependent spouse, do not complete the requirements of the Partnership Promise you and all of your covered dependents will be unable to enroll in the Partnership PPO for one year. Members who do not complete the requirements of the Partnership Promise will be sent written notification and will have the opportunity to respond to the notice.