



STATE OF TENNESSEE

GROUP INSURANCE PROGRAM ENROLLMENT/CHANGE APPLICATION

State of Tennessee Department of Finance and Administration Division of Insurance Administration
13th Floor, William R. Snodgrass TN Tower, Nashville, Tennessee 37243 615-741-3590/1-800-253-9981 Fax: 615-741-8196

See back for complete instructions. You must sign and date this form, even if refusing coverage. Please print clearly.

PART 1 ENROLLMENT/CHANGE REQUEST - Check all that apply.

ADD: New Eligible Employee, Late Enrollee, Add Spouse, Add Child(ren), Dental, Special Enrollment Provision
CHANGE: Transfer Plans, Change Name, Marital Status, Health/Dental, Type of Coverage from, Beneficiary
TERMINATE/REASON: Coverage: Self, Coverage: Spouse, Coverage: Child(ren), Dental, Optional Special Accident, Health
Terminate employment, Employee request, Divorce, Dependent age, Dependent married, Dependent no longer student, Dependent no longer claimed on federal income tax, Death

PART 2 EMPLOYEE INFORMATION - Must be completed, even if refusing coverage.

Social Security No., Last Name, First Name, Middle Initial, Street Address, Apt. #, City, State, Zip Code, County of Residence Code, County of Work Code, Gender, Marital Status, Birthdate, Department Name, Budget Code, Date Hired, Salary, Is your spouse a state employee?, Name, Social Security No., Department

PART 3 ENROLLMENT INFORMATION

Health: PPO, HMO*, POS*, Coverage Type: Single, Family, Split, Optional Life: Special Accident*, Term*, Universal Life*, Dental Plan: Prepaid Dental Plan*, Preferred Dental Organization (PDO), Type of Dental Coverage: Employee Only, Employee+1, Employee+2 or more

* Additional form needed. Please contact your department's insurance preparer.

PART 4 DEPENDENT INFORMATION - See back for definitions. Attach a separate sheet if necessary.

Table with columns: Social Security No., Name (Last, First, Mi), Birthdate (MM/DD/YY), Relationship Code, Sex (M/F), Acquire Date, Student (age 19-24) (Y/N), Coverage (Health/Dental)

PART 5 BASIC LIFE BENEFICIARY INFORMATION - (Does not apply to late enrollees if not approved.)

Name, Relationship, Complete Address

PART 6 AUTHORIZATION

ACCEPT: I confirm that all of the information provided above is accurate. I understand that knowingly providing false and/or misleading information may subject me to disciplinary and/or legal action...
REFUSAL: I have been given the opportunity by my employer to apply for the Group Insurance Program and after due consideration, have decided not to take advantage of this offer.

I am currently enrolled in another health insurance plan: Yes No

I acknowledge receipt of my employee handbook and accept all the terms and conditions contained therein.

Employee Work Telephone, Employee Home Telephone, Signature, Date

INSTRUCTIONS

PART 1 ENROLLMENT/CHANGE REQUEST

- Add: Check all appropriate boxes.
 Change: Check desired change/enrollment with effective date.
 Terminate: Date coverage is to be cancelled—this must be requested in advance. Check all coverages to be cancelled.
 Reason: Date of event is date of marriage, birth, divorce, etc. Check the appropriate reason.

PART 2 EMPLOYEE INFORMATION

Complete each line in full. County Codes are listed below. If your spouse is a state employee, please complete the requested information about him/her.

PART 3 ENROLLMENT INFORMATION

Health: The name of the HMO or POS for which you are enrolling must be listed and a physician selection card must be completed. Eligibility for an HMO or POS is based on your county of work or residence. These service areas are listed in the *Medical Plans Comparison Summary* brochure.

Type of Coverage: Single covers employee only.
 Family covers employee and all eligible dependents.
 Single split covers a state plan employee whose spouse is also covered by the state plan.
 Split covers a state plan employee and all eligible dependents if your spouse is also covered by the state plan with single split coverage.

Optional Life: Additional application forms are required.

Dental: Coverage is optional. Additional forms are required for the prepaid plan.

Anytime you elect to cover dependents, you must complete PART 4.

PART 4 DEPENDENT INFORMATION

Refer to your employee handbook for dependent eligibility rules. If you elect to cover dependents, you must provide all information requested in Part 4 for each dependent. You must provide a social security number for any dependent two years of age or older.

RELATIONSHIP CODES	ACQUIRE DATE
SP Legally married spouse	Date of marriage
CN Natural child	Date of birth
CN Legally adopted child	Date of placement for adoption
CS Stepchild for whom you or your spouse has legal or joint custody	Date custody obtained or marriage date
CL Any child for whom you are the legal guardian	Date appointed guardian
CT Any child you claim as a dependent for federal income tax	Date you were able to claim child

IMPORTANT: It is your responsibility to notify your insurance preparer of any changes in the eligibility status of a dependent within five working days.

The following are *not eligible* for coverage as your dependent through the State Group Insurance Program:

- Ex-spouse (even if court ordered).
- Parents of the employee or spouse.
- Children in the armed forces on a full-time basis.
- Children over age 24 (unless they meet qualifications for incapacitation).
- Married children, regardless of age.
- Foster children.
- Live-in companions not legally married to the employee.

Acquire Dates are needed solely for the purposes of determining eligibility.

STUDENT: Check Yes or No for any unmarried dependent child older than 18 years and 11 months of age. A full-time student is one who is registered for at least the number of credit hours that the institution requires in its definition of full-time student status and who attends classes for two of three semesters or three of four quarters in any 12-month period.

COVERAGE HEALTH/DENTAL: Check block(s) to show coverage selected for each dependent.

PART 5 BENEFICIARY INFORMATION

If you enroll in an optional life program, a separate form must be completed to designate a beneficiary.

PART 6 AUTHORIZATION

Check a block either accepting or refusing coverage. You must sign and date the form.

COUNTY CODES

001 Anderson	017 Crockett	033 Hamilton	049 Lauderdale	065 Morgan	081 Stewart
002 Bedford	018 Cumberland	034 Hancock	050 Lawrence	066 Obion	082 Sullivan
003 Benton	019 Davidson	035 Hardeman	051 Lewis	067 Overton	083 Sumner
004 Bledsoe	020 Decatur	036 Hardin	052 Lincoln	068 Perry	084 Tipton
005 Blount	021 DeKalb	037 Hawkins	053 Loudon	069 Pickett	085 Trousdale
006 Bradley	022 Dickson	038 Haywood	054 McMinn	070 Polk	086 Unicoi
007 Campbell	023 Dyer	039 Henderson	055 McNairy	071 Putnam	087 Union
008 Cannon	024 Fayette	040 Henry	056 Macon	072 Rhea	088 Van Buren
009 Carroll	025 Fentress	041 Hickman	057 Madison	073 Roane	089 Warren
010 Carter	026 Franklin	042 Houston	058 Marion	074 Robertson	090 Washington
011 Cheatham	027 Gibson	043 Humphreys	059 Marshall	075 Rutherford	091 Wayne
012 Chester	028 Giles	044 Jackson	060 Maury	076 Scott	092 Weakley
013 Claiborne	029 Grainger	045 Jefferson	061 Meigs	077 Sequatchie	093 White
014 Clay	030 Greene	046 Johnson	062 Monroe	078 Sevier	094 Williamson
015 Cocke	031 Grundy	047 Knox	063 Montgomery	079 Shelby	095 Wilson
016 Coffee	032 Hamblen	048 Lake	064 Moore	080 Smith	096 Out of State