Benefit Enrollment Checklist

Name: _____ Personnel #/UTC ID: _____

Department: _____ Hire date: _____

Please select one: Enrollment deadline: _____

☐ Exempt (monthly salary)

☐ Non-exempt (hourly, paid biweekly)

Do you have prior State of Tennessee service? YES / NO
If yes, please give name of institution and approximate dates:

To be completed by Human Resources:

Retirement forms for exempt employees: Sent to UT Retirement: _____

☐ Notice of Election to Participate in ORP or TCRS

☐ Premium Distribution Specification Form (only needed if electing ORP)

Must confirm TIAA / Voya account is open.

Required Insurance forms: Sent to UT Insurance: _____

☐ Enrollment Change Application *(Carrier networks and family tiers must be selected)*

- ☐ Health: Premier PPO, Standard PPO, or CDHP/HSA
- ☐ Dental: Delta DPPO or Cigna DHMO
- ☐ Vision: Basic or Expanded
- ☐ Short-term Disability: 14-day or 30-day elimination (waiting) period

☐ Basic Term Life/AD&D Enrollment Application

- ☐ Department-paid and Employee-paid
- ☐ Department-paid only *(cannot enroll dependents or increase coverage)*

☐ Proof of dependent eligibility if anything other than employee-only coverage is selected

Optional Insurance forms:

☐ Voluntary AD&D *(Volume of Coverage must be selected)*

☐ Long-Term Disability (Reliance Standard form)

☐ HSA Payroll deduction form

☐ FSA Election and Compensation Reduction Agreement

☐ 403(b) Salary Reduction Form (*Must confirm TIAA / Voya account is open.)*

Online Enrollment Reminders:

☐ Voluntary Term Life Insurance: lifebenefits.com/statoftn

☐ UT Payroll Beneficiary: https://irisweb.tennessee.edu/irj/portal

☐ 401(k) Traditional or Roth and 457(b): RetireReadyTN.gov

Notes:

BENEFITS ORIENTATION

INSTRUCTIONS: Please put a check beside each item explained, or information supplied in orientation.

_____ 1. Employee Handbook (UT Chattanooga)
_____ 2. Annual Open Enrollment
_____ 3. Basic Group Insurance Plan
Medical, Basic Term life, Basic Accidental death & Dismemberment
_____ 4. Optional Special Accident Insurance
_____ 5. Optional Term Life Insurance
_____ 6. Vision Insurance
_____ 7. Dental Insurance
Prepaid Plan (DHMO) and DPPO
_____ 8. Health Insurance Options
_____ 9. Long Term Disability Insurance
_____ 10. Short Term Disability Insurance
_____ 11. Tax Deferred Income Plans/Roth 401k
_____ 12. Retirement Plans
_____ 13. Flexible Spending Account/HSA Account
_____ 14. COBRA
_____ 15. Employee Assistance Program (EAP)
_____ 16. Tuition Fee Wavier and Spouse-Dependent Fee Discount
_____ 17. Longevity Pay
_____ 18. Sick Leave Bank
_____ 19. Worker's Compensation: **Required to review website**
_____ 20. Holiday & Closing Schedule Leave Time
Holiday, Administrative Closing, Annual Leave, Sick Leave,
Personal Day (non-exempt only)
_____ 21. Family Medical Leave
_____ 22. Other Benefits: Bookstore Discount (except text books), Library Privileges, Exercise Facilities, Credit Union, United Way, etc.

****READ**** I understand that the health, dental, vision and optional special accident insurance is prepaid one month in advance. Depending on the timing of this orientation, or when I return completed paperwork, there may be a double deduction in my premium for one month or an off cycle premium taken out in the next paycheck or two in order to bring my premiums current.

I understand that I am responsible to read the UT Chattanooga handbook, review websites, and is my responsibility to go the UT Human Resources Policies. I am also responsible to check with TN Benefits Administration and TCRS Dept for any information on my insurances and retirement.

Sign name: _____

UT PN#: _____ OR UTCID#_____

Orientation Date: _____

RESET

KEYED: _____
VERIFIED: _____
PER# _____

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

2023 ENROLLMENT CHANGE APPLICATION

University of Tennessee • Payroll, Benefits and Retirement • Benefits Administration
505 Summer Place - UT Tower 907 • Knoxville, TN 37902 • 865.974.5251 • utinsurance@tennessee.edu

PARTNERS FOR HEALTH

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

TYPE OF ACTION
- ❑ Add coverage
- ❑ Change coverage

Form not for cancellation

COVERAGE
- ❑ Health
- ❑ Dental
- ❑ Vision
- ❑ Disability

PARTICIPANTS AFFECTED
- ❑ Employee
- ❑ Spouse
- ❑ Child(ren)

REASON FOR THIS ACTION
- ❑ New Hire/Newly Eligible
- ❑ Court Order
- ❑ Other _____

Life Event
- ❑ Marriage
- ❑ Newborn
- ❑ Legal Guardianship
- ❑ Adoption

Special Enrollment
- ❑ Death
- ❑ Divorce
- ❑ Loss of Eligibility

PART 2: EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER	MARITAL STATUS
				❑ M ❑ F	❑ S ❑ M ❑ D ❑ W

SOCIAL SECURITY NUMBER	EMPLOYING AGENCY	EMPLOYER GROUP:	YOUR CURRENT STATUS
	University of Tennessee	☑ HED	❑ Active ☐

HOME ADDRESS	❑ 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
- ❑ Premier PPO
- ❑ CDHP/HSA
- ❑ Standard PPO

SELECT A CARRIER & NETWORK
- ❑ BCBS Network S
- ❑ BCBS Network P *
- ❑ Cigna LocalPlus
- ❑ Cigna Open Access *

*higher premium applies

SELECT A HEALTH PREMIUM LEVEL
- ❑ employee only
- ❑ employee + child(ren)
- ❑ employee + spouse
- ❑ employee + spouse + child(ren)

PART 4: DENTAL COVERAGE SELECTION

SELECT A PLAN
- ❑ Delta Dental DPPO
- ❑ Cigna DHMO (Prepaid)

SELECT A DENTAL PREMIUM LEVEL
- ❑ employee only
- ❑ employee + child(ren)
- ❑ employee + spouse
- ❑ employee + spouse + child(ren)

PART 5: VISION COVERAGE SELECTION

SELECT A PLAN
- ❑ Basic Plan
- ❑ Expanded Plan

EyeMed Vison

SELECT A VISION PREMIUM LEVEL
- ❑ employee only
- ❑ employee + child(ren)
- ❑ employee + spouse
- ❑ employee + spouse + child(ren)

PART 6: DISABILITY SELECTION (UT)

SHORT TERM DISABILITY
- ❑ 14 day Elimination Period
- ❑ 30 day Elimination Period

LONG TERM DISABILITY
Complete the separate Lincoln Natl. form found on the HR New Emp Welcome site
hr.utk.edu/welcome/

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
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ F			❑	❑	❑

* 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 mid-year, I may be eligible for changes in enrollment of plan members and dependents as a special enrollment. 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.

❑ 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 special qualifying event or wait until annual enrollment.

*** EMPLOYEE SIGNATURE	DATE	HOME PHONE (REQUIRED)	EMAIL ADDRESS (REQUIRED)

AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR

ORIGINAL HIRE DATE	COVERAGE BEGIN DATE	POSITION NUMBER	EDISON ID	NOTES TO BENEFITS ADMINISTRATION
				❑ PPACA Eligible ❑ 1450 Eligible

AGENCY BENEFITS COORDINATOR SIGNATURE	DATE

Active employees should return this completed form to your agency benefits coordinator.

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 • Government-issued marriage certificate or license • Naturalization papers indicating marital status
		Additional Documents • 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 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.	Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent's 26th birthday. 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.
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.

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

BASIC TERM LIFE/AD&D INSURANCE ENROLLMENT/CHANGE APPLICATION

University of Tennessee • Payroll, Benefits and Retirement • Benefits Administration
505 Summer Place - UT Tower 907 • Knoxville, TN 37902 • 865.974.5251 • utinsurance@tennessee.edu

PART 1: TYPE OF REQUEST

ENROLLMENT	☐ New Hire ☐ Newly Eligible	☐ Special Enrollment* Complete page 2 and page 3 (if applicable) and return to your agency benefits coordinator.	☐ Update Dependent(s) ☐ Add** ☐ Terminate Complete page 2 and return to your agency benefits coordinator.
☐ Add Coverage ☐ Change Coverage			

BENEFICIARY DESIGNATION	Beneficiary Designation Effective Date: _____ Complete page 2 and return to your agency benefits coordinator.
☐ Add ☐ Change	

PART 2: ELECT COVERAGE

☐ Employee only	☐ Employee + spouse	☐ Employee + spouse + child(ren)	☐ Employee + child(ren)

☐ I want department-paid and employee-paid basic term life/AD&D employee coverage. Note: This is 1.5 times my base annual salary as of date of hire or Sept. 1 of each year (effective Oct. 1) with a maximum basic term life coverage of $50,000 and basic AD&D coverage of two times the basic term life coverage. (Eligible dependents may be enrolled with this option.)

☐ I am requesting to enroll dependents [Complete page 2 and page 3 (if applicable). Return to your agency benefits coordinator.]

☐ I only want department-paid basic term life/AD&D coverage. **Note: You may not enroll dependents or increase your coverage above the state-paid amount in the future unless you have a special qualifying event.**

PART 3: EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER ☐M ☐F	MARITAL STATUS ☐S ☐M ☐D ☐W

SOCIAL SECURITY NUMBER	EMPLOYING AGENCY University of Tennessee at Chattanooga	DAYTIME PHONE NUMBER	EDISON ID

HOME ADDRESS	CITY	ST	ZIP CODE

PART 4: EMPLOYEE AUTHORIZATION

I understand this enrollment is only for basic term life/basic AD&D coverage and that it is up to me as the employee to designate a beneficiary. I further understand that I can only change my beneficiary designation(s) in Edison or by completing a new application and returning it to my agency benefits coordinator. If I fail to designate a beneficiary, I understand, that in the event of my death, proceeds will be paid to my spouse, children, parents, or estate according to applicable certificate of coverage provisions.

I authorize the State Group Insurance Program to release information to its life insurance contractor on behalf of myself and all family members required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force while I have a pending application or maintain enrollment with the SGIP's life insurance company. The SGIP will not condition treatment, payment, or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.

I confirm that all information I have provided herein is accurate and that I may be subject to disciplinary and/or legal action if I provide false and/or misleading information. I authorize my employer to deduct the required premium from my salary/wages.

_____ _____

EMPLOYEE SIGNATURE DATE

PART 5: AGENCY SECTION – MUST BE COMPLETED BY AGENCY BENEFITS COORDINATOR

HIRE DATE	ABC SIGNATURE/DATE

NAME	EDISON ID	OR	SSN

DEPENDENT INFORMATION – SEE STATEMENT AT THE TOP OF PAGE 3

Name (First, MI, Last)	Date of birth	Relationship	Gender	Acquire date	SSN

☐ A separate sheet with more dependents is attached

PRIMARY BENEFICIARY DESIGNATION

1.	NAME	PHONE NUMBER	SSN	RELATIONSHIP		BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE	
2.	NAME	PHONE NUMBER	SSN	RELATIONSHIP		BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE	
3.	NAME	PHONE NUMBER	SSN	RELATIONSHIP		BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE	
ADD PRIMARY BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.					**TOTAL BENEFIT %:**	

CONTINGENT BENEFICIARY DESIGNATION

1.	NAME	PHONE NUMBER	SSN	RELATIONSHIP		BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE	
2.	NAME	PHONE NUMBER	SSN	RELATIONSHIP		BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE	
3.	NAME	PHONE NUMBER	SSN	RELATIONSHIP		BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE	
ADD CONTINGENT BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.					**TOTAL BENEFIT %:**	

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 615-532-9617.

If you think you have been treated in a different way for these reasons, please mail this information to the Civil Rights Coordinator for the Department of Finance and Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 20th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 615-532-9617.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697 **OR** U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531 **OR** Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

If you speak a language other than English, help in your language is available for free.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298).

866 (رقم -576-0029- مملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك باالمجان. اتصل برقم 1.(800-848-0298- هاتف الصم والبكم: 1

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-576-0029 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለውቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-576-0029 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

توجه: اگر هب زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما 866-576-0029 (TTY: 1-800-848-0298) فراهم می باشد. با تماس بگیرید