

## 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?

If yes, please give name of institution and approximate dates:

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**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

*(Required 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
- Long-Term Disability: *\*Automatic enrollment for some LTD coverage.*  
Employee to confirm employer-paid or employee-paid option.
- Basic Term Life/AD&D Enrollment Application *(Automatic, State-paid enrollment)*
- Full coverage: 1x annual base salary - \$50,000 minimum to \$250,000 maximum (default option)
- Coverage capped at \$50,000
- 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)*
- 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](http://lifebenefits.com/statoftn)
- UT Payroll Beneficiary: <https://irisweb.tennessee.edu/irj/portal>
- 401(k) Traditional or Roth and 457(b): [RetireReadyTN.gov](http://RetireReadyTN.gov)

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Notes:





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 <b>Form not for cancellation</b>	<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.**

<b>SELECT AN OPTION</b> <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 <a href="mailto:utinsurance@tennessee.edu">utinsurance@tennessee.edu</a></p>	<b>SELECT A CARRIER &amp; NETWORK</b> <input type="checkbox"/> BCBS Network S <input type="checkbox"/> BCBS Network P* <input type="checkbox"/> Cigna LocalPlus <input type="checkbox"/> Cigna Open Access* <small>*higher premium applies</small>	<b>SELECT A HEALTH PREMIUM LEVEL</b> <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**

<b>SELECT A PLAN</b> <input type="checkbox"/> Delta Dental DPPO <input type="checkbox"/> Cigna DHMO (Prepaid Provider)	<b>SELECT A DENTAL PREMIUM LEVEL</b> <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)	<b>PART 5: VISION COVERAGE SELECTION</b> <b>SELECT A PLAN</b> <input type="checkbox"/> Basic Plan <input type="checkbox"/> Expanded Plan	<b>SELECT A VISION PREMIUM LEVEL</b> <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)	<b>PART 6: DISABILITY SELECTION (ST/UT/TBR)</b> <b>SHORT TERM DISABILITY</b> <input type="checkbox"/> 60%/14 day Elimination Period <input type="checkbox"/> 60%/30 day Elimination Period	<b>LONG TERM DISABILITY</b> <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
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**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 <b>AND</b> one document from the additional documents list below:
		<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>Additional Documents</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” or “married filing separately” with the name of the spouse provided thereon; submit page 1 of the return with the income figures blacked out</li> </ul>
		<b>If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility</b>
Natural (biological) child under age 26	A natural (biological) child	The child’s birth certificate (will accept mother’s copy for newborn); <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	Final court order granting adoption; <b>or</b>
		International adoption papers from country of adoption; <b>or</b>
		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) <b>and</b> birth certificate of the child showing the relationship to the spouse, <b>or</b> 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; <b>and</b> 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 Chattanooga • Office of Human Resources • Insurance Dept 3603  
720 McCallie Ave • Chattanooga, TN 37403 • office 423.425.4452 • fax 423.425.4574

**PART 1: TYPE OF REQUEST**

<b>ENROLLMENT</b>		<input type="checkbox"/> New Hire	<input type="checkbox"/> Qualifying Event Change Request*
<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Change Coverage	<input type="checkbox"/> Newly Eligible	Complete page 2 and page 3 (if applicable) and return to your agency benefits coordinator within the allowed timeframe.
<b>BENEFICIARY DESIGNATION</b>		Beneficiary Designation Effective Date: _____	
<input type="checkbox"/> Add <input type="checkbox"/> Change		Complete page 2 and return to your agency benefits coordinator.	

**PART 2: ELECT COVERAGE**

Employee only:

I want full employee coverage paid by the state [Note: This is one times my base annual salary as of hire or Sept. 1 of each year (effective Jan. 1) with a minimum basic term life coverage of \$50,000 and a maximum coverage of \$250,000; coverage is reduced at ages 65, 70, and 75. Basic AD&D coverage is one times basic term life coverage. Imputed income, as explained in IRS Publication 15, for basic term life coverage above \$50,000 will be shown on employee's W2.]

I want only \$50,000 of employee coverage paid by the state even though I qualify for coverage above \$50,000 (Note: Coverage may be less than \$50,000 if calculated coverage due to age is less than \$50,000.)

**PART 3: 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		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 (SGIP) to release information to its life insurance contractor on behalf of myself 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
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NAME	EDISON ID	OR	SSN
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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
4.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
5.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
<b>ADD PRIMARY BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.</b>					<b>TOTAL BENEFIT %:</b>

CONTINGENT BENEFICIARY DESIGNATION (TO RECEIVE DEATH BENEFITS WHEN NO LIVING PRIMARY BENEFICIARY)					
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
4.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
<b>ADD CONTINGENT BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.</b>					<b>TOTAL BENEFIT %:</b>

As required by law, a Summary of Benefits and Coverage is available which describes your 2024 health coverage options. The SBC may be found at [www.tn.gov/ParTNersForHealth/summary-of-benefits-and-coverage](http://www.tn.gov/ParTNersForHealth/summary-of-benefits-and-coverage) no later than Sept. 1. The digital newsletter contains much of the same information. To get a SBC paper copy, free of charge, call 855.809.0071. Please include your name, complete mailing address and name of the SBCs you want: State and Higher Education Plan; Local Education Plan; or Local Government Plan.

The Plans are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to PHI. Find Notice of Privacy Practice and other important Legal Notices including Prescription Drug Coverage and Medicare and more at [https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/legal\\_notices.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/legal_notices.pdf)

Find the Notice Regarding Wellness Program at [tn.gov/ParTNersForHealth](http://tn.gov/ParTNersForHealth) under Wellness, or email [benefits.info@tn.gov](mailto:benefits.info@tn.gov) to request a mailed copy of the Wellness Program Notice.

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, contact the Finance and Administration Civil Rights Coordinator at [FA.CivilRights@tn.gov](mailto:FA.CivilRights@tn.gov) or 615-532-9617.

**Have you been denied services or treated differently for the above stated reasons?** Find the Department of Finance and Administration's Nondiscrimination Policy and Complaint Procedures and Form under F&A Department Policies at <https://www.tn.gov/finance/looking-for/policies.html> (Policy 36); contact the F&A Civil Rights Coordinator; or mail a complaint to F&A Civil Rights Coordinator/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 such as braille or large print? If you speak a language other than English, help in your language is available for free. Contact the F&A Civil Rights Coordinator at 615-532-9617.

**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 (مكبل او مصلا فتاه -800-848-0298) 1. مقرب ل صتا . ناجم لاب كل رفاوتت وىوغلل ادعاسم ل تامدخ نإف ، نغللل ركذنا ثدحتت تنك انا: وظوح ل-576-0029- (مقرب) 866

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 cho bạn. 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 kalan- gan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848- 0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገኙዎት ተዘጋጅተዋል፡ ወደ ሚኮተለው-ቁጥር ይደውሉ 1-866-576-0029 (ማስማት 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 નિ:શુલ્ક 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 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 हृद्धि 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).

866-576-0029 (TTY: 1-800-848-0298) دی ریگب سامت هرامش نی اب . دشابایم مهارف امش یارب ناگیار تروصب ی نابز تالی هست ، دینکیم وگتفنگ ی سراف نابز هب رگا : هجوت 1-800-848-0298)

If you have questions about civil rights compliance or concerns, you may also contact:

- 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, GA 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697.
- U.S. Office for Civil Rights, Office of Justice Programs, U.S. Department of Justice, 810 7th Street, NW, Washington, DC 20531.
- Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.