STATE OF TENNESSEE GROUP INSURANCE PROGRAM

EMPLOYEE INSURANCE CHECKLIST — STATE PLAN

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, Tennessee 37243 • 615.741.3590 or 800.253.9981

DO NOT submit this form to Benefits Administration. This form must be completed during an employee's initial enrollment period. Place a check mark beside each item discussed. After completing the form, place the original in the employee's insurance or personnel file and give the employee a copy.

EMPLOYEE INFORMATION

NAME	EDISON ID	AGENCY

ELIGIBILITY AND ENROLLMENT

- ❑ Explain the eligibility criteria for employees and dependents.
- ❑ Explain enrollment must be completed within 30 days of their eligibility date. If completing a paper form, it must be returned to the human resource office with the applicable dependent verification documents by _____ to allow ABC time to submit a Benefit eForm to BA within the 30-day requirement. If electronic enrollment is available through Edison Employee Self Service, the enrollment with dependent verification must be submitted by _____. Paper application is not necessary if using ESS. Explain enrollment in voluntary term life insurance is through the vendor's website.
- ❑ Explain new hire coverage start date. Most coverages start on the first day of the month after your hire date AND completion of one calendar month of employment. Voluntary term life coverage requires completion of three calendar months of eligible employment. Partial months worked will not count toward the employment requirement. Subject to meeting ALL eligibility and enrollment requirements, your coverage start date will be _____ for voluntary term life. Your coverage start date for other insurance benefits will be _____.
- ❑ Explain if not enrolled when first eligible, the employee will only be allowed insurance coverage during the year by approval through a special enrollment provision. If a completed application is not returned by the 15th of the month prior to coverage beginning, the employee may have double deductions on the first paycheck from which health premiums are collected. Explain guaranteed issue for disability and voluntary term life insurance.
- ❑ Explain changes which can be made during the fall annual enrollment period, effective the following January 1.
  - Employees/dependents may request to enroll in, cancel or transfer between health options and carriers
  - Employees/dependents may request to enroll in, cancel or transfer between dental and vision options
  - Employees may request to apply for short term and/or long term disability
  - Employees/dependents may request to enroll in voluntary accidental death insurance and apply for voluntary term life
  - Employees may request to start a flexible spending account

INSURANCE PRODUCTS

Health Options — each allows a choice of carrier and network

- ❑ Premier Preferred Provider Organization
- ❑ Standard PPO
- ❑ Consumer-driven Health Plan with a health savings account

Life Options

- ❑ Basic Term Life and Accidental Death and Dismemberment
- ❑ Voluntary Term Life
- ❑ Voluntary Accidental Death and Dismemberment

Other

- ❑ Dental — Prepaid and Preferred Provider
- ❑ Vision — Basic and Expanded Plans
- ❑ Flexible Benefits
- ❑ Short Term Disability (State and Higher Education)
- ❑ Long Term Disability (State Only)

INFORMATION TO BE PROVIDED

- ❑ Provide Edison login, password and ESS instructions.
- ❑ If the Edison password is not set up timely to complete ESS, provide an application to process insurance elections through a Benefit eForm. Also provide Basic Life Beneficiary Designation Application and Voluntary AD&D Insurance Application. The beneficiary designations, life insurance forms and enrollment application must be signed and placed in the employee's insurance/personnel file even if refusing coverage. Or provide this navigational path to enter beneficiary information in Edison: HCM>Benefits>Employee/Dependent Information>Life Insurance Beneficiaries.
- ❑ Explain that BA/ParTNers for Health will communicate to member using contact information provided, including email address.
- ❑ Provide the ParTNers for Health URL, tn.gov/partnersforhealth. Describe information located there, including vendor materials, publications and the customer service page (emphasize search feature for network providers) with contact information for BA and vendor partners.
- ❑ Explain where to find online forms for health, dental, disability, vision, life, retirement, leave of absence, flexible benefits enrollment and reimbursement and miscellaneous forms, provide printed copies if requested. Provide the url to the voluntary term life insurance website.
- ❑ Provide access to the eligibility and enrollment guide and HIPAA privacy notice or printed copies if requested.
- ❑ Explain the benefits available through the Employee Assistance Program and the wellness program.
- ❑ Explain flexible, medical, limited purpose, dependent care, transportation and parking reimbursement accounts.
- ❑ Explain the benefits available in the health, dental, disability, life and vision insurance programs.
- ❑ Explain monthly premiums, including employee deduction and employer contribution.
- ❑ Explain the deferred compensation choices and provide enrollment form or the web address to enroll.
- ❑ Provide the web address to the TennCare notice so employee is aware of responsibilities if they or their dependents are enrolled in TennCare.
- ❑ Explain the Summary of Benefits and Coverage and the marketplace letter and provide the web address or printed copies if requested.

EMPLOYEE SIGNATURE

AGENCY BENEFITS COORDINATOR SIGNATURE

DATE

DATE

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ENROLLMENT & SPECIAL QUALIFYING EVENT CHANGE APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 800.253.9981 • fax 615.741.8196

PARTNERS FOR HEALTH

PART 1: ACTION REQUESTED

TYPE OF ACTION
- ❑ Add coverage
- ❑ Add coverage & change benefit election
- ❑ Annual Enrollment Revision

COVERAGE
- ❑ Health ❑ Dental
- ❑ Vision ❑ Disability

PARTICIPANTS AFFECTED
- ❑ Employee ❑ Spouse
- ❑ Child(ren) (complete Part 3)

REASON FOR THIS ACTION
- ❑ Properly served National Medical Support Notice
- ❑ Annual Enrollment Revision
- ❑ Qualifying enrollment event (select one & provide documentation):
  - ___ **Acquisition of new dependent** due to: ❑ Marriage ❑ Legal Guardianship ❑ Newborn ❑ Adoption
  - ___ **Loss of eligibility for other group coverage/TennCare/CHIP**
  - ___ **New eligibility for premium subsidy**

PART 2: EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER	MARITAL STATUS
				❑ M ❑ F	❑ Single ❑ Married ❑ Divorced ❑ Widowed

SOCIAL SECURITY NUMBER	EMPLOYING AGENCY	EMPLOYER GROUP	CURRENT STATUS
		❑ HED ❑ State ❑ Local Ed ❑ Local Gov	❑ Active ❑ COBRA

HOME ADDRESS ❑ UPDATE MY ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: SPOUSE/CHILD(REN) TO BE ADDED — ATTACH A SEPARATE SHEET IF NECESSARY

(Check Health, Dental, Vision boxes below for coverage requested)

NAME (FIRST MI LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE	SOCIAL SECURITY NUMBER	HEALTH	DENTAL	VISION
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ F			❑	❑	❑

❑ **A separate sheet with more dependents is attached**

PART 4: HEALTH INSURANCE

SELECT A HEALTH COVERAGE OPTION
- ❑ Premier PPO ❑ Standard PPO
- ❑ CDHP/HSA (HED or state only)
  State HSA participants, enter **annual** contribution: $_____
- ❑ Limited PPO (Local Ed & Local Gov Only)
- ❑ Local CDHP/HSA (Local Ed & Local Gov Only)
- ❑ Decline Health Insurance

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 5: DENTAL INSURANCE

SELECT A DENTAL PLAN
- ❑ Delta Dental DPPO
- ❑ Cigna DHMO (Prepaid Provider)
- ❑ Decline Dental Insurance

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

PART 6: VISION INSURANCE

SELECT A VISION PLAN
- ❑ Basic Plan
- ❑ Expanded Plan
- ❑ Decline Vision Insurance

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

PART 7: DISABILITY INSURANCE (ST/UT/TBR)

SHORT TERM DISABILITY
- ❑ 60% with 14-day Elimination Period
- ❑ 60% with 30-day Elimination Period
- ❑ Decline Short Term Disability insurance

LONG TERM DISABILITY
- ❑ Employer-paid DEFAULT STATE/HE 63% with 90-day Elimination Period
- ❑ Employee-paid 60% with 90-day Elimination Period
- ❑ Employee-paid 60% with 180-day Elimination Period
- ❑ Employee-paid 63% with 180-day Elimination Period

PART 8: EMPLOYEE AUTHORIZATION

❑ I confirm that the information above is true. I understand my health, dental, and vision selections may not be changed until the end of the applicable plan year, and that I cannot change insurance plans or carriers during the plan year unless I experience a qualifying event. If I am a state employee, I further agree that my share of premiums for the coverages selected above will be deducted from my pay on a pre-tax basis. I understand that it is my responsibility to notify my agency benefits coordinator if any of my dependents lose eligibility, and I understand that I will be held responsible for any claims paid in error if I fail to notify.

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

PART 9: AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR

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

SQE ENROLLMENT CHANGES

DEADLINES, EFFECTIVE DATES AND REQUIRED DOCUMENTATION

PARTNERS FOR HEALTH

1. LOSS OF ELIGIBILITY		
Loss of Eligibility under another group insurance plan for any reason (including divorce, death of spouse, involuntary loss of other government coverage)	• Only the employee and any dependents who have lost or will lose eligibility may enroll. Individuals who lose other coverage may only enroll in the types of coverage lost (medical/medical; dental/dental; vision/vision). A voluntary action that results in loss of coverage is NOT a qualifying event, including a voluntary cancellation of coverage, a cancellation of coverage for not paying premiums, or electing to cancel, waive, or decline coverage during another plan's enrollment period. • If adding dependents to existing health insurance coverage, you and your dependents may transfer to a different carrier or healthcare option, if eligible	**Deadline:** Application for enrollment with required documentation must be received by the ABC or BA within 60 days of the loss of eligibility. **Effective date:** First day of the month after a completed application with documentation is received by the ABC or BA. **Documentation required:** 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
2. ACQUISITION OF NEW DEPENDENT		
• Spouse or Stepchild by Marriage	• The employee may enroll in employee only or family coverage. • The employee may add new dependent and any eligible dependents who were not enrolled when initially eligible and are still eligible. • If adding dependents to existing health insurance coverage, you and your dependents may transfer to a different carrier or healthcare option, if eligible. • HOC and eligible dependents may enroll in dental and vision coverage if the requirements stated in the dental or vision certificates of coverage are met.	**Deadline:** Application for enrollment with required documentation* must be received by the ABC or BA within 60 days of the date of acquisition (the date of acquisition is the date of the marriage or the date of the placement order). **Effective date:** First day of the month after a completed application with documentation is received by the ABC or BA. **Documentation required:** 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
• By Order of Guardianship	• No employee-only coverage is permitted. • All change requests due to an Order of Guardianship must arise out of and correspond with the terms of the guardianship order. • HOC and eligible dependents may enroll in dental and vision coverage if the requirements stated in the dental or vision certificates of coverage are met.	
• By Birth, Adoption, or Placement for Adoption	• Enrollment should be completed and submitted to the ABC or BA within 30 days to ensure the earliest possible effective date. • The employee may enroll in employee only or family coverage. • The employee may add the new dependent and any other eligible dependents who were not enrolled when initially eligible and are otherwise still eligible. • If dependents are added to existing health insurance coverage, HOC and eligible dependents may transfer to a different carrier or healthcare option, if eligible. • HOC and eligible dependents may additionally enroll in dental and vision coverage if the requirements stated in the dental or vision certificates of coverage are met (no retroactive coverage is available for dental and vision).	**Deadline:** Application for enrollment with required documentation* must be received by the ABC or BA **within 30 days** of the birth, adoption, or placement of adoption for retroactive health insurance coverage (with an **effective date** of the date of birth, adoption, or placement for adoption). Other coverage (dental/vision) will begin the first day of the month following the enrollment request. An application with required documentation* that is **received by the ABC or BA 31 to 60 days** after the birth, adoption, or placement for adoption will result in an effective date of the first day of the following month. **Documentation required:** 1. Birth Certificate (will accept mother's copy for newborn) 2. Final Order of Adoption or Order of Custody in anticipation of adoption

Examples of deadlines and effective dates for new dependents (assuming that all eligibility requirements are met and all required documentation is submitted with application)

	Marriage June 15	**Birth, Adoption,** or **Placement for Adoption** June 15
Within 30 days	If Enrollment is submitted to BA on June 25 (within 30 days of marriage): All coverage will begin July 1, first day of the month following submission of completed application	If Enrollment is submitted to BA on June 25 (within 30 days of birth): Health insurance will be retroactive to June 15, date of birth All other coverage (dental/vision) will begin July 1, first day of the month following submission of completed application
31-60 days	If Enrollment is submitted to BA on August 14 (60 days after marriage): All coverage will begin September 1, first day of the month following submission of completed application	If Enrollment is submitted to BA on July 16 (31 days after birth): All coverage will begin August 1, first day of the month following submission of completed application If Enrollment is submitted to BA on August 14 (60 days after birth): All coverage will begin September 1, first day of the month following submission of completed application
After 60 days	An Enrollment submitted on or after August 15 (61 days after event) will exceed the 60-day enrollment period, and the request will be denied.	

3. NEW ELIGIBILITY FOR PREMIUM SUBSIDY
An employee and any dependents newly eligible for a premium subsidy through a CHIP or Medicaid program may enroll in health insurance coverage midyear. The application for enrollment with documentation must be received by the ABC or BA within 60 days of the new eligibility.

* Required documentation for adding new dependents may be submitted up to 10 days after the applicable enrollment deadline.

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 ❑ Add Coverage ❑ Change Coverage	❑ New Hire ❑ Newly Eligible	❑ Qualifying Event Change Request* Complete page 2 and page 3 (if applicable) and return to your agency benefits coordinator within the allowed timeframe.
BENEFICIARY DESIGNATION ❑ Add ❑ Change	Beneficiary Designation Effective Date: _____ Complete page 2 and return to your agency benefits coordinator.	

PART 2: ELECT COVERAGE

Central State Government and State Higher Education 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.)

State Offline Agency Employee Only

❑ I want full employee coverage. I will be responsible for paying all of the premiums. [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 with premiums paid by me 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.)

❑ I decline to enroll in Basic Term Life/Basic AD&D coverage

PART 3: EMPLOYEE INFORMATION

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

NAME	EDISON ID	OR	SSN

PRIMARY BENEFICIARY DESIGNATION

	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
1.					
HOME ADDRESS		CITY	STATE	ZIP CODE	
2.					
HOME ADDRESS		CITY	STATE	ZIP CODE	
3.					
HOME ADDRESS		CITY	STATE	ZIP CODE	
4.					
HOME ADDRESS		CITY	STATE	ZIP CODE	
5.					
HOME ADDRESS		CITY	STATE	ZIP CODE	
ADD PRIMARY BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.				**TOTAL BENEFIT %:**	

CONTINGENT BENEFICIARY DESIGNATION (TO RECEIVE DEATH BENEFITS WHEN NO LIVING PRIMARY BENEFICIARY)

	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
1.					
HOME ADDRESS		CITY	STATE	ZIP CODE	
2.					
HOME ADDRESS		CITY	STATE	ZIP CODE	
3.					
HOME ADDRESS		CITY	STATE	ZIP CODE	
4.					
HOME ADDRESS		CITY	STATE	ZIP CODE	
ADD CONTINGENT BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.				**TOTAL BENEFIT %:**	

NAME	EDISON ID	OR	SSN

***CHANGE REQUEST: You may have additional opportunities to change your Basic Term Life/AD&D coverage if you have a qualifying event as described below.**

INSTRUCTIONS: Check the box in the qualifying event section below to identify the event which applies to you. Submit this page along with the required documentation and your completed application.

NOTE: Application for a coverage change must be made within 60 days of the loss of eligibility for other insurance coverage or within 30 days of an acquire event. 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.

The earliest effective date allowed for a coverage change under this plan is the first day of the month following the date that your request, including all required documentation, is completed and submitted to BA. Coverage change requests 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 change request.

EXAMPLE 1	EXAMPLE 2
Marriage date is June 15 (30- day change request period applies): • change request submitted to BA on June 25 = 7/1 effective date • change request submitted to BA on July 10 = 8/1 effective date • change request submitted on or after July 16 will exceed the 30-day change request period, and your request will be denied	**Loss of other coverage date is June 30 (60-day change request period applies):** • change request submitted to BA on June 30 = 7/1 effective date • change request submitted to BA on July 10 = 8/1 effective date • change request submitted to BA on August 5 = 9/1 effective date • change request 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
❑ An event causing the loss of eligibility for coverage from another group life insurance plan***	The effective date is the first day of the first calendar month after the date BA receives the request for coverage change	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; (3) types of coverage (medical, dental, life, 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
❑ 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 coverage change	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
❑ 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 first day of the first calendar month after the date BA receives the request for coverage change	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 who lost the other coverage may request a coverage change under this plan to the type(s) of other coverage lost.

**** In the case of an acquire event, an Employee may only request to change his or her coverage. There is no option to add dependents.