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

INSTRUCTIONS AND INFORMATION FOR FORM 1043

READ CAREFULLY BEFORE COMPLETING APPLICATION

- If you are an ACTIVE EMPLOYEE, the completed form must be returned to your Agency Benefits Coordinator (ABC).

- If you are a COBRA participant, the form must be returned directly to Benefits Administration by:
  - mailing to the address above
  - emailing benefits.administration@tn.gov; or
  - faxing to 615-741-8196

- Complete the entire form and do not leave anything blank. Leaving a section blank can cause a delay in processing your request.

- You must send required documentation with your completed form:
  - For completing Part 1 "Reason For This Action", if you check "Qualifying Enrollment Event", see page 2 for acceptable documentation.
  - For completing Part 3:
    - Proof of a dependent's eligibility must be submitted with your application for all dependents being added to a plan. Click HERE for acceptable documentation, or go to www.tn.gov/content/dam/tn/finance/fa-benefits/documents/deva_eligible_docs.pdf
    - Note that "Acquire Date" is date of marriage, birth, adoption, placement of adoption, or guardianship.

- Do not send original documents to support the enrollment application. Redact/black out any Social Security numbers and any personal financial information on the copies of your documents.

- Premiums are not prorated. If approved, you must pay the required premium for the entire month in which the effective date occurs.

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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: ❑ HED ❑ State ❑ Local Ed ❑ Local Gov	CURRENT STATUS ❑ 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.

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 denied services or treated differently for any of the above stated reasons, please find the TN Department of Finance and Administration's Non Discrimination and Complaint Policy at https://www.tn.gov/finance/looking-for/policies.html for guidance or contact the Department of Finance and Administration Civil Rights Coordinator at FA.CivilRights@tn.gov or 615.532.9617 for assistance.

You may request information regarding anti-discrimination or a Civil Rights Complaint form by mail to: State of Tennessee, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243 or by email to FA.CivilRights@tn.gov.

You may also request information regarding anti-discrimination from or submit a Complaint to:
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.

Need free language help? If you speak a language other than English, help in your language is available for free. If you have a disability and need an auxiliary aid or service, for instance sign language, Braille, or large print, help is available for free. Please request language assistance by emailing renee.woodall@tn.gov and FA.CivilRights@tn.gov or calling 615.253.9926.

Spanish

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

Arabic

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

Chinese

注意：如果您會說中文，則提供免費的語言協助服務。 請致電 1-866-576-0029（電傳打字機：1-800-848-0298）。

Vietnamese

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

Korean

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

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1800-848-0298).

Laotian

ຂໍ້ຄວນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີຢູ່. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

Amharic

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

German

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

Gujarati

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).

Japanese

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

Tagalog

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).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1800-848-0298) पर कॉल करें।

Russian

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

Persian

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