Reset

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ENROLLMENT CHANGE APPLICATION

Knox County Schools - Benefits and Employee Relations Department
Post Office Box 2188 - Knoxville, TN 37901-2188 - Fax (865) 594-9523

PARTNERS FOR HEALTH

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

TYPE OF ACTION	COVERAGE	PARTICIPANTS AFFECTED	REASON FOR THIS ACTION		
❑ Add coverage	☑ Health	❑ Employee	❑ New Hire/Newly Eligible	Life Event	Special Enrollment (also complete pg 3)
❑ Change coverage		❑ Spouse	❑ Court Order	❑ Marriage	❑ Death
		❑ Child(ren)	☑ Other _____	❑ Newborn	❑ Divorce
				❑ Legal Guardianship	❑ Loss of Eligibility
				❑ Adoption	

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: ❑ HED ❑ State ❑ Local Ed ❑ Local Gov	YOUR CURRENT STATUS
			❑ Active ❑ COBRA

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	LOCAL ED & GOV ONLY MAY ALSO CHOOSE	SELECT A CARRIER & NETWORK	SELECT A HEALTH PREMIUM LEVEL
❑ Premier PPO	❑ Limited PPO	❑ BCBS Network S	❑ employee only
❑ Standard PPO	❑ Local CDHP/HSA	❑ BCBS Network P*	❑ employee + child(ren)
		❑ Cigna LocalPlus	❑ employee + spouse
		❑ Cigna Open Access*	❑ employee + spouse + child(ren)
		*higher premium applies	

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		
			❑ 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 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

AGENCY BENEFITS COORDINATOR SIGNATURE	DATE

❑ PPACA Eligible ❑ 1450 Eligible

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

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
Child under age 18 for whom the participant is legal guardian	A child under age 18 for whom the participant is the legal guardian	Court order appointing the member a guardian of the child, requiring financial support of the child, mandating insurance coverage of the child, and stating the length of the guardianship
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.

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Never send original documents. Please mark out or black out any social security numbers and any personal financial informationon the copies of your documents BEFORE you return them.