

## STATE OF TENNESSEE GROUP INSURANCE PROGRAM

## DENTAL INSURANCE APPLICATION — COBRA OR RETIREE



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

## Complete in blue or black ink.

| PART 1: ACTION F   | REQUESTE    | D   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|--|-------------|---|--------------------|----------------------|-------------------|---------------------------------|------------------------|-----------------------------------|--------------------|------------------|----------------|--|
| PARTICIPANT STATUS   |             | ADD   | ADD                |                      |                   | CHANGE                          |                        |                                   |                    | TERMINATE        |                |  |
| ☐ COBRA  |             | ☐ Coverage: Sel                                       | ☐ Coverage: Self   |                      |                   | ☐ Transfer to Delta Dental DPPO |                        |                                   |                    | ☐ Coverage: Self |                |  |
| ☐ Retiree  |             | ☐ Coverage: Spo                                       | ☐ Coverage: Spouse |                      |                   | ☐ Transfer to Cigna DHMO (F     |                        |                                   | ☐ Coverage: Spouse |                  |                |  |
|  |             | ☐ Coverage: Chi                                       | ild(ren)           |                      | Provi             | der)                            |                        |                                   | ☐ Co               | verage: Chil     | d(ren)         |  |
| PART 2: APPLICAT   | NT INFORM   | MATION  |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
| LAST NAME  |             |   | FIRS               | ST NAME              |                   |                                 | MI                     | SSN OR EDISO                      | N ID               |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  | T           |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
| DATE OF BIRTH  |             |   |                    | GROUP: UT TBR        |                   |                                 | DESIRED EFFECTIVE DATE |                                   |                    |                  |                |  |
| □ M □ F  |             |   | <b>L</b> ocal Ed   | Local Ed 🚨 Local Gov |                   |                                 |                        |                                   |                    |                  |                |  |
| HOME ADDRESS   |             |   | CITY               | Y                    |                   |                                 | ST                     | ZIP CODE                          |                    | COUNTY           |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
| PART 3: DENTAL C   | OVERAGE     | SELECTION   |                    |                      | CELECT            | A DEN                           | TAL DDE                | MIUM LEVEL                        |                    |                  |                |  |
|  |             |   |                    |                      | self              |                                 | IIAL PKEI              | self + spouse                     |                    |                  |                |  |
| Delta Dental Dental Preferred Provider Organization (DPPO)   |             |   |                    | act a                |                   | •                               |                        |                                   |                    | •                |                |  |
| ☐ Cigna Dental Health Maintenance Organization — You MUST seld general dentist from the list of participating network dentists             |             |   |                    |                      | self + child(ren) |                                 |                        | $\Box$ self + spouse + child(ren) |                    |                  |                |  |
| DART 4: DEDENDE  | NT INFOR    | MATION — LIST ALL                                     | DEDENDEN           | NTS VOLL             | WISHT             | ט כטי                           | /FR (att               | ach a sonarat                     | o shoo             | if necessa       | arv)           |  |
| SOCIAL SECURITY N  |             |   | AST, FIRST, MI     |                      | WISIT             |                                 | HDATE                  | GENDER                            |                    | ATIONSHIP        | ACQUIRE DATE * |  |
| SOCIAL SECORIT I   | IOWIDEN     | NAME (L   | A31, FIN31, WII    | ,                    |                   | DINI                            | HUATE                  | GENDER                            | NEL/               | AHONSHIP         | ACQUIRE DATE   |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        | □M□F                              |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        | □M□F                              |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
| * The acquire date is  | the date of | marriage, birth, adoptio                              | on or guardia      | anship.              |                   |                                 |                        |                                   |                    | oparato cho      | oot with more  |  |
| Proof of a dependent's eligibility must be submitted with this application for all new dependents.  A separate sheet with more dependents. |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
| PART 5: AUTHORI  | ZATION      |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             | oove is true. I understar                             | nd my dental       | l selection          | n is effec        | tive un                         | til the en             | d of the plan ve                  | ear (Dec           | ember 31).       | subject to     |  |
|  |             | cannot change insurar                                 |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             | embers and dependen                                   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             | sible criminal penalties.<br>erminate at the end of t |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
| any claims paid in er  |             |   | ne montinin        | WITICIT              | e 1033 01         | engibii                         | iity occui             | s. i unuerstanu                   | tilatiw            | ili be field f   | esponsible for |  |
| SIGNATURE  |             |   | DATE               | DATE                 |                   |                                 | HOME PHONE             |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
| EMAIL ADDRESS  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |
|  |             |   |                    |                      |                   |                                 |                        |                                   |                    |                  |                |  |

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## **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:   |  |  |  |  |  |
|  |   | 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<br>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  | Final court order granting adoption; <b>or</b>   |  |  |  |  |  |
|  | the process of legally adopting   | 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<br>one of the child categories previously listed<br>and due to a mental or physical disability,<br>is unable to earn a living. The dependent's | 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.  The insurance carrier will review the form, make a determination and provide BA with   |  |  |  |  |  |
|  | disability must have begun before age 26 and while covered under a state-sponsored plan.  | documentation once a determination has been made. If approved for incapacity, the child will continue the same coverage.   |  |  |  |  |  |
| Child under age 26 placed<br>for guardianship, custody<br>or conservatorship with the<br>head of contract*<br>(placement order active or<br>expired due to age of<br>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   |  |  |  |  |  |

<sup>\*</sup>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.

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