RESET

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

PARTNERS FOR HEALTH

**Complete in blue or black ink.**

## PART 1: ACTION REQUESTED

| PARTICIPANT STATUS | ADD | CHANGE | TERMINATE |
|---|---|---|---|
| ❑ COBRA | ❑ Coverage: Self | ❑ Transfer to Delta Dental DPPO | ❑ Coverage: Self |
| ❑ Retiree | ❑ Coverage: Spouse | ❑ Transfer to Cigna DHMO (Prepaid Provider) | ❑ Coverage: Spouse |
| | ❑ Coverage: Child(ren) | | ❑ Coverage: Child(ren) |

## PART 2: APPLICANT INFORMATION

| LAST NAME | FIRST NAME | MI | SSN OR EDISON ID |
|---|---|---|---|
| | | | |

| DATE OF BIRTH | GENDER | MARITAL STATUS | EMPLOYER/RETIREE GROUP: ❑ UT ❑ TBR ❑ State ❑ Local Ed ❑ Local Gov | DESIRED EFFECTIVE DATE |
|---|---|---|---|---|
| | ❑ M ❑ F | | | |

| HOME ADDRESS | CITY | ST | ZIP CODE | COUNTY |
|---|---|---|---|---|
| | | | | |

## PART 3: DENTAL COVERAGE SELECTION

**SELECT A PLAN**

❑ Delta Dental of TN Dental Preferred Provider Organization (DPPO)

❑ Cigna Dental Health Maintenance Organization — You MUST select a general dentist from the list of participating network dentists

**SELECT A DENTAL PREMIUM LEVEL**

❑ self only ❑ self + spouse

❑ self + child(ren) ❑ self + spouse + child(ren)

## PART 4: DEPENDENT INFORMATION — LIST ALL DEPENDENTS YOU WISH TO COVER (attach a separate sheet if necessary)

Proof of a dependent's eligibility must be submitted with this application for all new dependents (review document here).

| SOCIAL SECURITY NUMBER | NAME (LAST, FIRST, MI) | BIRTHDATE | GENDER | RELATIONSHIP | ACQUIRE DATE * |
|---|---|---|---|---|---|
| | | | ❑ M ❑ F | | |
| | | | ❑ 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.

❑ A separate sheet with more dependents is attached

## PART 5: AUTHORIZATION

I confirm that the information above is true. I understand my dental selection is prospective and remains 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. I understand that submission of fraudulent information may lead to consequences including cancellation of insurance 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.

| SIGNATURE | DATE | HOME PHONE |
|---|---|---|
| | | |

| EMAIL ADDRESS |
|---|
| |