

The following information must be supplied if you are applying sixty (60) days or more past your first Medicare eligibility date.

Retiree Information

Do you now have or have you had in the last five years any of the following:

Yes	No		If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (not skin cancer)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure	_____

Spouse Information

Do you now have or have you had in the last five years any of the following:

Yes	No		If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (not skin cancer)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure	_____

Dependent Information

Do you now have or have you had in the last five years any of the following:

Yes	No		If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (not skin cancer)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure	_____

I am applying for the Tennessee Plan coverage.

I understand that my Tennessee Plan coverage will be effective on the date shown in the material to be received from the insurance provider. I understand that I will have the right to review the benefits booklet. I understand that if I am not enrolled in Medicare, the Tennessee Plan will not provide benefits. I also understand that if I am enrolled in TennCare, I do not need a supplement plan. I further understand that if I am enrolled in a Medicare HMO, I do not need this supplement plan.

The information provided on this form is accurate and truthful to the best of my knowledge and belief for the purpose of determining my insurance eligibility. I understand that knowingly providing false and/or misleading information may subject me to legal action and may result in loss of insurance coverage and recovery of any claims paid under this contract. I further understand that proof of this information may be requested at any time. I agree to retain Medicare Parts A and B for myself or dependents that are applying. Also, I am aware that the State of Tennessee's supplement does not offer any pharmacy benefits; therefore, I must enroll in Medicare Part D or subscribe to another supplemental for pharmacy needs.

Date _____	Signature of TCRS Retired Member _____
Date _____	Spouse's Signature (if applying) _____
Date _____	Dependent's Signature (if applying) _____