

Application for State Premium Assistance

State of Tennessee • Department of Finance and Administration



Return applications to:

AccessTN c/o BCBST
801 Pine Street, Chattanooga TN 37402

AccessTN is administered by BlueCross BlueShield of Tennessee, Inc.
 -an independent Licensee of the BlueCross BlueShield Association

You may be eligible for premium assistance if your household income (what the IRS calls “total adjusted gross income”) is \$75,000 or less. Complete this form and send to us to determine if you qualify. The AccessTN premium assistance program will be administered by Patient Services, Inc. (PSI). Remember that premium assistance is only available for Plan 1000.

Complete only if applying for premium assistance. When submitted, this will become part of your AccessTN Application for Health Coverage. It should be signed and complete to be considered. Some questions are repeated from the Application for Health Coverage to aid processing.

NOTE: Premium assistance will be offered only as funding is available.

Applicant Name: Last: _____ First: _____ MI: _____			Date of Birth: _____
Mailing Address: _____			Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
City: _____	State: _____	Zip Code: _____	County: _____
Home Phone () _____	Work Phone () _____	Cell/Mobile Phone () _____	SSN _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Email Address if OK to communicate with you by email _____	
What is your preferred language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ <input type="checkbox"/> Check for language help			

Are you at or below the target weight for your height? <input type="checkbox"/> Yes <input type="checkbox"/> No (see plan materials or www.AccessTN.gov for height/weight tables)	Weight _____
Have you used tobacco products during the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Height _____

<u>Names of other members of household</u>	<u>Age</u>	<u>Relationship to Applicant</u>	<u>Is this person your legal dependent for tax purposes?</u>
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Add additional pages if necessary. We will notify you when your application is processed or if we need additional information.
 Premium and premium assistance tables can be found in the plan overview booklet or at www.AccessTN.gov.

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Financial Documentation Required to Process Assistance Application

Check the financial documents you are providing and attach copies of each to this application. AccessTN will keep your copies. Please do not send originals of your important papers. Make a copy of everything you send for your own records.

___ Copy of pages 1 and 2 of most recent Federal Tax Form 1040 as filed with the Internal Revenue Service (must be signed and dated, but we do not need schedules or attachments unless requested.) **OR**

You can submit proof of your household income by providing the following types of income documentation. Check the income documents you are submitting for all members of your household:

- | | |
|--------------------------------------|------------------------------------|
| ___ 2 recent consecutive pay stubs | ___ Social Security benefit letter |
| ___ W-2 Form | ___ Pension Statements |
| ___ Form 1099 | ___ Proof of alimony received |
| ___ SSI or SSDI determination letter | ___ Proof of alimony paid* |
| ___ Other (please list: _____) | |

*If you are NOT submitting a copy of your Federal Tax Form, we will only be able to adjust your gross income for alimony paid. To do so, you must attach a copy of the legal decree showing the amount of alimony and copies of cancelled checks or other proof of payment for the last 2 consecutive months.

Note: You must re-qualify for premium assistance on an annual basis. However, if you experience changes in your financial status (i.e. income, employment, marital, insurance eligibility) anytime during the year, you are required to immediately notify us.

BlueCross BlueShield of Tennessee, Inc. is the Plan Administrator of all AccessTN benefit plans. PSI and Blue Cross BlueShield of Tennessee, Inc. are independent organizations except that each has contracted to administer separate parts of the AccessTN program and will be cooperating to assist you with their respective services.

AccessTN has selected Patient Services, Inc. (PSI), a 501(c)(3) charitable organization, to administer the AccessTN premium assistance program. They may contact you for this purpose. PSI is an independent non-profit organization that assists patients with certain specific chronic illnesses and conditions.



I hereby give my consent to Patient Services, Inc. (PSI) to obtain, and verify my medical, insurance and/or financial information to determine if I qualify for Access TN premium assistance.

___ (optional- please put your initials if OK) I also consent for PSI to use my information to apply for any additional financial assistance programs that PSI determines may be possible based on my diagnoses.

If you choose to apply for AccessTN premium assistance, this application for State Premium Assistance shall be incorporated by reference, in its entirety, into your AccessTN Application for Health Coverage. By your signature below, you are specifically reaffirming Section G, "Protected Health Information", and Section I, "Statement of Understanding and Affirmation" of that document and you agree that those provisions shall apply to all information submitted as part of this Application for State Premium Assistance.

By your signature, you acknowledge that you have read the sections above, and you certify that the information submitted is true and accurate to the best of your knowledge and belief. This Application for State Premium Assistance should be sent in with your Application for Health Insurance Coverage. Faxed applications will not be accepted.

Signature of Applicant (original required)

Date

Signature of Legal Guardian if Applicant is Not Legally Competent

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Call 1-866-636-0080 toll free if you have questions or need help with these papers.

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