RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

INSURANCE CANCEL REQUEST APPLICATION

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

NAME	EDISON ID	EMPLOYER GROUP: ☐ HED ☐ STATE ☐ LOCAL ED ☐ LOCAL GOV

PART 1 — PARTICIPANT(S) CANCELING COVERAGE (ATTACH A SEPARATE SHEET IF NECESSARY)

I request to cancel ☐ medical ☐ dental ☐ STD ☐ LTD ☐ vision ☐ FSA/medical ☐ FSA/dep care ☐ FSA/limited ☐ Voluntary AD&D coverage on the participant(s) below due to:

☐ Reason marked in Part 2 below

☐ Prepaid dental; no participating general dentist within a 40-mile radius of my home (skip Parts 2 and 3 below)

☐ Disability; requires 30 days advance written notice (skip Parts 2 and 3 below)

☐ Employee ☐ Spouse ☐ Child(ren) (names):

INSTRUCTIONS

You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment period except for one of the following events. (Note: STD and/or LTD may be canceled during the year for any reason.)

1. You and/or your dependent(s) may cancel coverage if you lose eligibility or qualify to cancel for one of the reasons listed below. Only persons who qualify may cancel. You have 60 days from a qualifying event to submit documentation.
2. If enrolled in the prepaid dental option and there is no participating general dentist within a 40-mile radius of your home. The coverage end date will be the last day of the month that this form is received by Benefits Administration.

The purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordinator.

PART 2 — REASON TO REQUEST TO CANCEL

REASON	DOCUMENTATION REQUIRED
☐ Marriage, divorce, legal separation, annulment	Copy of marriage certificate or full divorce decree or legal paperwork signed by judge and proof of other coverage (see #1 above) If divorce, please provide ex-spouse's current address here:
☐ Birth, adoption, placement for adoption	Copy of birth certificate or adoption documents and proof of other coverage (see #1 above)
☐ Death of spouse, dependent	Copy of death certificate
☐ New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependent)	Letter on employer's company letterhead certifying date of insurance eligibility, date of return from unpaid leave or change in employment status
☐ Entitlement to Medicare, Medicaid, TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card
☐ Court decree or order	Copy of court decree or order signed by judge
☐ Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage
☐ A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)	Letter stating date of location change with member's new address
☐ Marketplace Enrollment	I attest that I am enrolled or intend to enroll in the Marketplace

PART 3 — REQUESTED COVERAGE END DATE

The coverage end date may either be the last day of the month prior to the eligibility date of other coverage or the last day of the month that the event occurred.	LAST DAY COVERAGE TO BE ACTIVE (MM/DD/YY)

PART 4 — AUTHORIZATION

By signing this application, I attest that I and/or my dependent(s) are eligible to cancel coverage for the reason(s) marked in Part 1 of this form. I also attest that I can cancel disability coverage for any reason. I further attest that the information I am submitting is true and accurate. I understand that by making this request, the participant(s) whose coverage is cancelled may not be eligible for COBRA and that any future request for coverage will be subject to the Plan's eligibility and enrollment rules.

EMPLOYEE SIGNATURE	DATE	PHONE
AGENCY BENEFITS COORDINATOR SIGNATURE	DATE	NOTES

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 1-866-576-0029.

If you think you have been treated in a different way for these reasons, please mail this information to Benefits Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Benefits Administration, Civil Rights Compliance, Department of Finance and Administration, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 1-866-576-0029.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697

If you speak a language other than English, help in your language is available for free. This tells you how to get help in a language other than English.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-576-0029 (رقم هاتف الصم والبكم: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-576-0029 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-576-0029 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-576-0029 (TTY: 1-800-848-0298) تماس بگیرید.