



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

VOLUNTARY ACCIDENTAL DEATH ENROLLMENT APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

TYPE OF REQUEST		ACTION FOR ENROLLMENT CHANGE	
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Terminate Coverage	
<input type="checkbox"/> Employee only	<input type="checkbox"/> Terminate Dependent	<input type="checkbox"/> Add/Change Beneficiary	
<input type="checkbox"/> Employee + dependents	<input type="checkbox"/> Update Dependent Eligibility	<input type="checkbox"/> Change Coverage Type to: <input type="checkbox"/> Single <input type="checkbox"/> Family	
<input type="checkbox"/> Enrollment Change	Effective Date of Change: _____		

EMPLOYEE INFORMATION					
FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
SOCIAL SECURITY NUMBER	EMPLOYING AGENCY		DAYTIME PHONE NUMBER	EDISON ID	
HOME ADDRESS			CITY	ST	ZIP CODE

DEPENDENT INFORMATION						
NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE *	SOCIAL SECURITY NUMBER	
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> 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.

AUTHORIZATION	
<p>I confirm that all the above information is accurate. I understand that providing false and/or misleading information may subject me to disciplinary and/or legal action. I authorize my employer to deduct the required premium from my salary/wages.</p> <p>I authorize the state group insurance program to release information to their life insurance contractor on behalf of myself and all family members (name, address, social security number, age, gender, salary, enrollment effective/termination date) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The state group insurance program will not condition treatment, payment or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.</p> <p>I understand that a new application must be completed and returned to my agency benefits coordinator any time I want to designate a new beneficiary. Failure to designate a beneficiary will result in the proceeds being paid to my spouse, children, parents or estate according to applicable contract provisions in the event of my death. Dependents do not elect a beneficiary as the benefit will automatically default to me as the employee.</p>	
EMPLOYEE SIGNATURE _____	DATE _____

Complete beneficiary designation on back of this application and return to your agency benefits coordinator

NAME		EDISON ID	OR	SSN	
PRIMARY BENEFICIARY DESIGNATION					
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
TOTAL FOR PRIMARY BENEFICIARY (MUST BE 100%)					TOTAL
CONTINGENT BENEFICIARY DESIGNATION					
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
TOTAL FOR CONTINGENT BENEFICIARY (MUST BE 100%)					TOTAL

NOTE: Contingent beneficiary will only receive benefits if all primary beneficiaries are deceased.