



AGENCY BENEFITS COORDINATOR USE

SSN _____

EMPLID _____

INSTRUCTIONS

This form is to be completed by a plan member to suspend insurance benefits while on leave without pay. You must sign, date and return this form to your agency benefits coordinator.

FAILURE TO SIGN AND SUBMIT THIS FORM TIMELY WILL IMPACT YOUR BENEFITS.

LEAVE WITHOUT PAY — SUSPEND COVERAGE

- Maximum period for suspension is two years.
- All state group insurance program benefits are suspended, including any voluntary coverage, with the exception of the \$20,000 basic term life and the \$40,000 basic accidental death and dismemberment coverages provided at no cost to all eligible state and higher education employees.
- You must request to suspend coverage by completing this form prior to going on an approved leave.
- Premiums must be paid current and not be in a past-due status. You cannot request suspension if your premiums are past due.
- Re-enrollment is not automatic.
- Within 31 days after returning to active employment, you must complete an enrollment change application to re-enroll (90 days if returning from military leave).
- If you fail to re-enroll timely, you must wait until the fall enrollment period unless you become eligible during the year by satisfying one of the special enrollment provisions.
- Coverage will be effective the first of the month after you return to work and your request for reinstatement has been received by Benefits Administration.
- Refer to the Eligibility and Enrollment Guide for further information on reinstating coverage.

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME (PRINT)	SIGNATURE (REQUIRED)	DATE
-----------------------	----------------------	------

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

SUSPEND COVERAGE EFFECTIVE DATE (MUST BE FIRST OF MONTH)	
AGENCY	
AGENCY BENEFITS COORDINATOR SIGNATURE	DATE

Suspend coverage due to non-payment while on FMLA (employee signature not required).

Agency MUST notify Benefits Administration when the employee returns to work

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).

1 برقم اتصل به المجان لك توافر ال لغوية ال مساعدتخدمات ف إن ال لغة، انك رت تحدثت إن ال: بم لحوطة-576-0029-رقم) 866
1: وال بكم الصدم ه اتف-848-0298-800).

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 ohnte, 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: የጥናትና ጥራት አማራጭ ስህተት የትርጉም እርዳታ ድርጅቶች: በጎጂ ሊያግዝዎት ተዘጋጅተዋል: 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).

تماس با ما به اشده می فراهم م 866-576-0029 (TTY: 1-800-848-0298) شم ابرای رایگان بصورت زبانی تسهیلات کنید، می گفتگو فراسی زبانی به اگر: توجه
به گیرید.