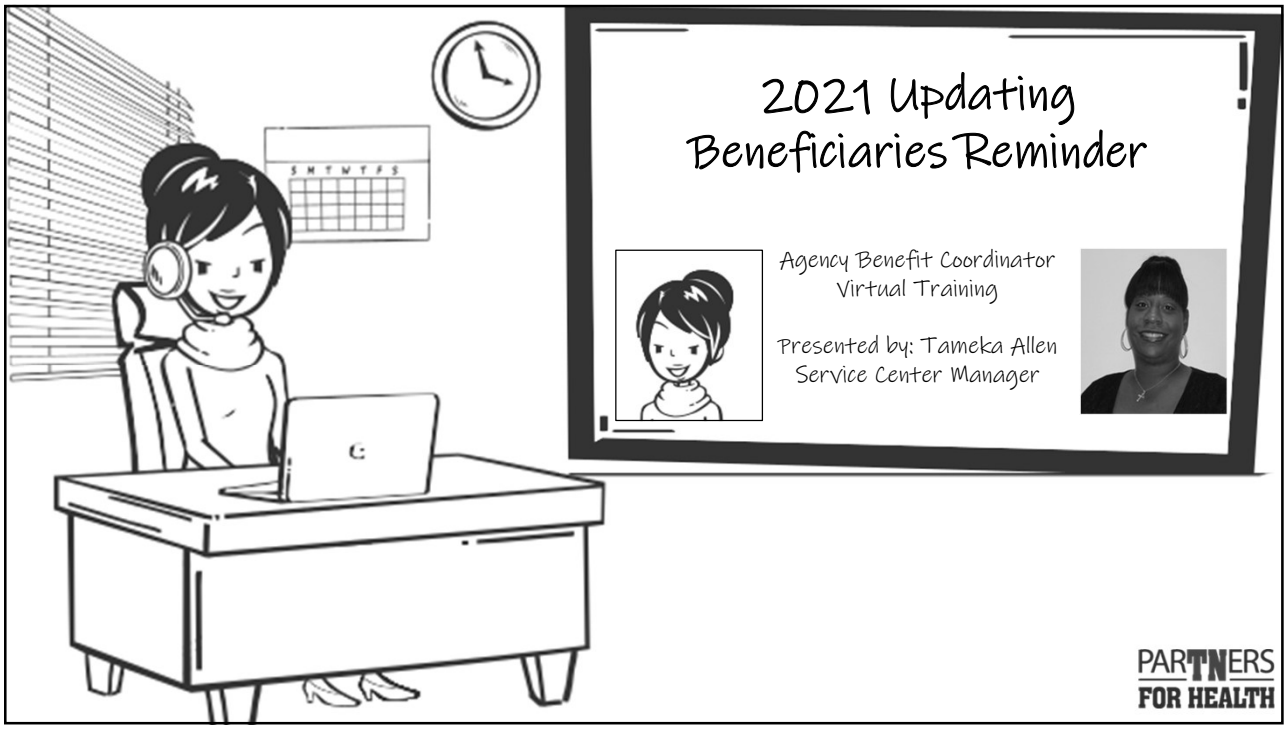
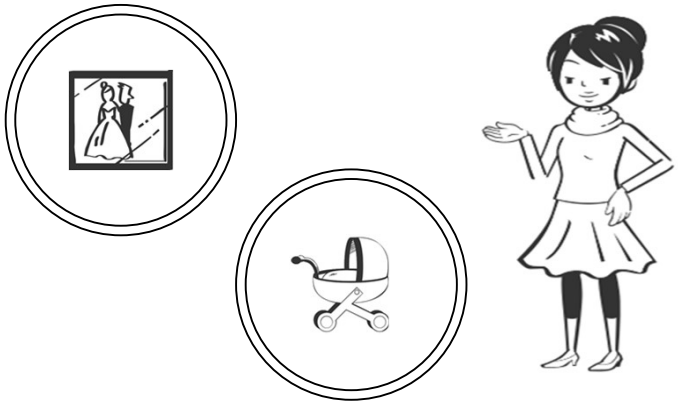


1

When Do We Need to Update Our Beneficiaries?

Beneficiaries should be updated anytime you experience a Special Qualifying Event such as marriage or birth.



PARTNERS FOR HEALTH

2

Reminder

Effective immediately, our Active Service center will include beneficiary update reminders at the completion of processing Special Qualifying Events and Life Events.

- ❑ Marriage
- ❑ Divorce
- ❑ Loss of Employment/Loss of Eligibility
- ❑ Births & Adoptions
- ❑ Death of Dependents

PARTNERS FOR HEALTH

3

Updating Your Basic Term and Voluntary AD&D

Navigation Path

Edison
↓
Main Menu
↓
HCM
↓
Employee Self Service
↓
Benefits
↓
Dependents & Beneficiaries
↓
Life Insurance & Beneficiaries

PARTNERS FOR HEALTH

4

Updating Your Basic Term and Voluntary AD&D

Navigation Path

Edison
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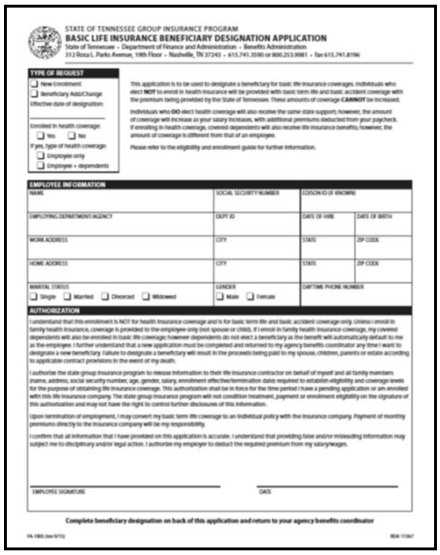

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

BASIC LIFE INSURANCE BENEFICIARY DESIGNATION 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
- ☐ New Enrollment
- ☐ Beneficiary Add/Change

Effective date of designation: _____

Enrolled in health coverage:
- ☐ Yes ☐ No

If yes, type of health coverage:
- ☐ Employee only
- ☐ Employee + dependents

This application is to be used to designate a beneficiary for basic life insurance coverages. Individuals who elect **NOT** to enroll in health insurance will be provided with basic term life and basic accident coverage with the premium being provided by the State of Tennessee. These amounts of coverage **CANNOT** be increased.

Individuals who **DO** elect health coverage will also receive the same state support; however, the amount of coverage will increase as your salary increases, with additional premiums deducted from your paycheck. If enrolling in health coverage, covered dependents will also receive life insurance benefits; however, the amount of coverage is different from that of an employee.

Please refer to the eligibility and enrollment guide for further information.

EMPLOYEE INFORMATION

NAME	SOCIAL SECURITY NUMBER	LOGON ID (IF KNOWN)	
EMPLOYING DEPARTMENT/AGENCY	DEPT ID	DATE OF HIRE	DATE OF BIRTH
WORK ADDRESS	CITY	STATE	ZIP CODE
HOME ADDRESS	CITY	STATE	ZIP CODE
MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed	GENDER ☐ Male ☐ Female	DAYTIME PHONE NUMBER	

AUTHORIZATION

I understand that this enrollment is NOT for health insurance coverage and is for basic term life and basic accident coverage only. Unless I enroll in family health insurance, coverage is provided to the employee only (not spouse or child). If I enroll in family health insurance coverage, my covered dependents will also be enrolled in basic life coverage; however dependents do not elect a beneficiary as the benefit will automatically default to me as the employee. I further 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.

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.

Upon termination of employment, I may convert my basic term life coverage to an individual policy with the insurance company. Payment of monthly premiums directly to the insurance company will be my responsibility.

I confirm that all information that I have provided on this application 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.

EMPLOYEE SIGNATURE _____ DATE _____

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

PARTNERS FOR HEALTH

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Updating Your Voluntary Term

Call 866-881-0631

Log on at https://lifebenefits.com/stateoftn

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Questions

PARTNERS FOR HEALTH

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