RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

# BASIC TERM LIFE/AD&D INSURANCE ENROLLMENT/CHANGE 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

## PART 1: TYPE OF REQUEST

| | | |
|---|---|---|
| **ENROLLMENT**<br>❑ Add Coverage<br>❑ Change Coverage | ❑ New Hire<br>❑ Newly Eligible | ❑ Qualifying Event Change Request*<br>Complete page 2 and page 3 (if applicable) and return to your agency benefits coordinator within the allowed timeframe. |
| **BENEFICIARY DESIGNATION**<br>❑ Add ❑ Change | Beneficiary Designation Effective Date: _____<br>Complete page 2 and return to your agency benefits coordinator. | |

## PART 2: ELECT COVERAGE

Employee only:

❑ I want full employee coverage paid by the state [Note: This is one times my base annual salary as of hire or Sept. 1 of each year (effective Jan. 1) with a minimum basic term life coverage of $50,000 and a maximum coverage of $250,000; coverage is reduced at ages 65, 70, and 75. Basic AD&D coverage is one times basic term life coverage. Imputed income, as explained in IRS Publication 15, for basic term life coverage above $50,000 will be shown on employee's W2.]

❑ I want only $50,000 of employee coverage paid by the state even though I qualify for coverage above $50,000 (Note: Coverage may be less than $50,000 if calculated coverage due to age is less than $50,000.)

## PART 3: EMPLOYEE INFORMATION

| FIRST NAME | MI | LAST NAME | DATE OF BIRTH | GENDER | MARITAL STATUS |
|---|---|---|---|---|---|
| | | | | ❑ M ❑ F | ❑ S ❑ M ❑ D ❑ W |

| SOCIAL SECURITY NUMBER | EMPLOYING AGENCY | DAYTIME PHONE NUMBER | EDISON ID |
|---|---|---|---|
| | | | |

| HOME ADDRESS | CITY | ST | ZIP CODE |
|---|---|---|---|
| | | | |

## PART 4: EMPLOYEE AUTHORIZATION

I understand this enrollment is only for basic term life/basic AD&D coverage and that it is up to me as the employee to designate a beneficiary. I further understand that I can only change my beneficiary designation(s) in Edison or by completing a new application and returning it to my agency benefits coordinator. If I fail to designate a beneficiary, I understand, that in the event of my death, proceeds will be paid to my spouse, children, parents, or estate according to applicable certificate of coverage provisions.

I authorize the State Group Insurance Program (SGIP) to release information to its life insurance contractor on behalf of myself required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force while I have a pending application or maintain enrollment with the SGIP's life insurance company. The SGIP 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.

I confirm that all information I have provided herein is accurate and that I may be subject to disciplinary and/or legal action if I provide false and/or misleading information. I authorize my employer to deduct the required premium from my salary/wages.

_____ _____

EMPLOYEE SIGNATURE DATE

## PART 5: AGENCY SECTION – MUST BE COMPLETED BY AGENCY BENEFITS COORDINATOR

| HIRE DATE | ABC SIGNATURE/DATE |
|---|---|
| | |

| NAME | EDISON ID | OR | SSN |
|---|---|---|---|
| | | | |

## PRIMARY BENEFICIARY DESIGNATION

| | NAME | PHONE NUMBER | SSN | RELATIONSHIP | BENEFIT % |
|---|---|---|---|---|---|
| 1. | | | | | |
| HOME ADDRESS | | | CITY | STATE | ZIP CODE |
| | | | | | |
| 2. | NAME | PHONE NUMBER | SSN | RELATIONSHIP | BENEFIT % |
| HOME ADDRESS | | | CITY | STATE | ZIP CODE |
| | | | | | |
| 3. | NAME | PHONE NUMBER | SSN | RELATIONSHIP | BENEFIT % |
| HOME ADDRESS | | | CITY | STATE | ZIP CODE |
| | | | | | |
| 4. | NAME | PHONE NUMBER | SSN | RELATIONSHIP | BENEFIT % |
| HOME ADDRESS | | | CITY | STATE | ZIP CODE |
| | | | | | |
| 5. | NAME | PHONE NUMBER | SSN | RELATIONSHIP | BENEFIT % |
| HOME ADDRESS | | | CITY | STATE | ZIP CODE |
| **ADD PRIMARY BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.** | | | | | **TOTAL BENEFIT %:** |

## CONTINGENT BENEFICIARY DESIGNATION (TO RECEIVE DEATH BENEFITS WHEN NO LIVING PRIMARY BENEFICIARY)

| | NAME | PHONE NUMBER | SSN | RELATIONSHIP | BENEFIT % |
|---|---|---|---|---|---|
| 1. | | | | | |
| HOME ADDRESS | | | CITY | STATE | ZIP CODE |
| | | | | | |
| 2. | NAME | PHONE NUMBER | SSN | RELATIONSHIP | BENEFIT % |
| HOME ADDRESS | | | CITY | STATE | ZIP CODE |
| | | | | | |
| 3. | NAME | PHONE NUMBER | SSN | RELATIONSHIP | BENEFIT % |
| HOME ADDRESS | | | CITY | STATE | ZIP CODE |
| | | | | | |
| 4. | NAME | PHONE NUMBER | SSN | RELATIONSHIP | BENEFIT % |
| HOME ADDRESS | | | CITY | STATE | ZIP CODE |
| **ADD CONTINGENT BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.** | | | | | **TOTAL BENEFIT %:** |

| NAME | EDISON ID | OR | SSN |
|---|---|---|---|
| | | | |

***CHANGE REQUEST: You may have additional opportunities to change your Basic Term Life/AD&D coverage if you have a qualifying event as described below.**

**INSTRUCTIONS:** Check the box in the qualifying event section below to identify the event which applies to you. Submit this page along with the required documentation and your completed application.

**NOTE: Application for a coverage change must be made within 60 days of the loss of eligibility for other insurance coverage or within 30 days of an acquire event. Voluntary actions resulting in loss of coverage (such as voluntary cancellation of coverage and cancellation for not paying premiums) ARE NOT qualifying events. Electing to cancel, waive or decline coverage during another plan's enrollment period IS NOT a qualifying event.**

The earliest effective date allowed for a coverage change under this plan is the first day of the month following the date that your request, including all required documentation, is completed and submitted to BA. Coverage change requests should be completed and submitted to BA as soon as possible to ensure the earliest possible effective date. The examples provided below assume all eligibility requirements are satisfied and that required documentation is submitted with change request.

| EXAMPLE 1 | EXAMPLE 2 |
|---|---|
| **Marriage date is June 15 (30- day change request period applies):**<br>• change request submitted to BA on June 25 = 7/1 effective date<br>• change request submitted to BA on July 10 = 8/1 effective date<br>• change request submitted on or after July 16 will exceed the 30-day change request period, and your request will be denied | **Loss of other coverage date is June 30 (60-day change request period applies):**<br>• change request submitted to BA on June 30 = 7/1 effective date<br>• change request submitted to BA on July 10 = 8/1 effective date<br>• change request submitted to BA on August 5 = 9/1 effective date<br>• change request submitted on or after August 30 will exceed the 60-day enrollment period, and your request will be denied |

| QUALIFYING EVENT | EFFECTIVE DATE | DOCUMENTATION REQUIRED |
|---|---|---|
| ❑ An event causing the loss of eligibility for coverage from another group life insurance plan*** | The effective date is the first day of the first calendar month after the date BA receives the request for coverage change | Written documentation from an employer, former employer, insurance company, or former insurance company on company letterhead that lists (1) names of covered participants; (2) dates of coverage; (3) types of coverage (medical, dental, life, vision); (4) each participant that lost eligibility for coverage; (5) the date of loss of eligibility to continue coverage, and (6) the reason why eligibility for coverage was lost |
| ❑ An event that results in acquisition of a new dependent spouse or stepchild acquired by marriage, or a child acquired pursuant to an order of guardianship**** | The effective date is the first day of the first calendar month after the date BA receives the request for coverage change | 1. Marriage Certificate<br>2. Birth Certificate (will accept mother's copy for newborn)<br>3. Order of Guardianship requiring financial support and provision of insurance coverage, which sets out the date of the guardianship period |
| ❑ An event that results in acquisition of a new dependent acquired by birth, adoption, or placement in legal custody for adoption**** | The effective date is the date of birth, adoption, or placement for adoption | 1. Birth Certificate (will accept mother's copy for newborn)<br>2. Final Order of Adoption or Order of Custody in anticipation of adoption |

*** When eligibility for coverage under other insurance is lost, only the Employee who lost the other coverage may request a coverage change under this plan to the type(s) of other coverage lost.

**** In the case of an acquire event, an Employee may only request to change his or her coverage. There is no option to add dependents.