RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

INSURANCE CANCEL REQUEST APPLICATION FOR RETIREMENT

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	SSN OR EDISON ID

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

I request to cancel ❑ medical ❑ dental ❑ vision
for the following participants:

❑ Retiree	❑ Spouse	❑ Child(ren) (names):

INSTRUCTIONS — Submit page one and two of this form with required documentation to Benefits Administration

Coverage may only be canceled under a plan during the annual enrollment period except as provided in the Medical Plan Documents or applicable Certificates of Coverage available at www.tn.gov/partnersforhealth. You must mark the reason you are requesting to cancel coverage in Parts 2 or 3 below.

1. Health, dental, and/or vision coverage may only be canceled mid-year for the following reasons:
   a. Losing eligibility under a plan or becoming newly eligible for other coverage;
   b. Annual enrollment of spouse's employer plan with different coverage periods;
   c. Change in residence outside of national service area; or
   d. Change to the DHMO dental network that results in no participating general dentist within a 25- mile driving distance of the Head of Contract's home permits
   cancellation of DHMO Dental only (not applicable to Dental PPO, health, or vision).
2. If Head of Contract loses eligibility under a health, dental, or vision plan or becomes newly eligible for other similar plan coverage (not including Medicare) and requests to cancel coverage, the HOC and all dependents' coverage will be canceled. If a dependent loses eligibility under a health, dental, or vision plan or becomes newly eligible for other similar plan coverage only that dependent may cancel coverage.

PART 2 — INVOLUNTARY CANCELLATION — Coverage ends at the end of the month of the loss of eligibility

REASON	DOCUMENTATION REQUIRED
❑ Loss of Spouse eligibility due to divorce, legal separation, legal annulment * Ex-Spouses are not eligible for coverage on the Plan	Final divorce decree, order of separation, or order of annulment signed by a judge. Must provide the ex-spouse's current address here:
❑ Death of spouse or dependent	Copy of death certificate of deceased individual

PART 3 — VOLUNTARY CANCELLATION — Coverage ends the last day of the month this form is received by BA*

❑ New eligibility for group health insurance/benefits through spouse or dependent's employer	Complete No. 1 of the Attestation/Certification in Part 4 below
❑ Annual enrollment into a spouse, former spouse, or dependent's employer's group plan	Complete No. 2 of the Attestation/Certification in Part 4 below
❑ Marketplace eligibility and enrollment (Only Applicable to health insurance Benefits)	Complete No. 3 of the Attestation/Certification in Part 4 below
❑ New entitlement to Medicare or Medicaid	Copy of new ID card or Letter of entitlement from Medicare or Medicaid
❑ Termination of child support order of dependent child provided by National Medical Support Notice	Copy of Notice of termination of National Medical Support Notice
❑ Change of residence out of the national service area	Date of location change with member's new address
❑ Dental DHMO change to the network resulting in no participating general dentist within a 25-mile driving distance of the Head of Contract's home (only applicable to DHMO)	Must be confirmed by the dental insurance carrier and BA

* All voluntary terminations are subject to review and approval by Benefits Administration *

PART 4 ATTESTATION / CERTIFICATION

INSTRUCTIONS
If the reason for your cancellation request requires an attestation/certification, complete the section below that applies to your situation. All requests are subject to review and approval by Benefits Administration in accordance with the Medical Plan Document or applicable Certificate of Coverage and applicable law.

1. New eligibility for group health insurance/benefits through spouse or dependent's employer.

   I hereby certify that on the following date: _____, the individuals listed in Part 1 became newly eligible for coverage under a group benefit plan of the employer of the member's Spouse or Dependent because of either (select one):

   ❑ a change in marital status
   ❑ a change in employment status

   Coverage under the new health plan (select one):
   ❑ is already in effect
   ❑ will begin _____

2. Annual enrollment into a spouse, former spouse, or dependent's employer's group plan.

   I hereby certify that on the following date: _____, the individuals listed in Part1 became eligible for coverage under a group benefit plan of the employer of the member's Spouse, former spouse, or Dependent because of the employer's annual enrollment.

   Coverage under the new health plan (select one):
   ❑ is already in effect
   ❑ will begin _____

3. Marketplace eligibility and enrollment.

   I hereby certify that on the following date: _____, the individuals listed in Part 1 became eligible for Marketplace health coverage.

   Coverage under the Marketplace health plan (select one):
   ❑ is already in effect
   ❑ will be in effect no later than the day immediately following the last day of my Tennessee State sponsored health insurance coverage

PART 5 — AUTHORIZATION

By signing this Cancel Request Application, I attest and certify that I have read the instructions above and that the individuals listed in Part 1 of this form are eligible to cancel coverage for the reason(s) marked on this form. I certify that all of the statements on this form are true and accurate to the best of my knowledge and agree to provide appropriate documentation and paperwork to verify the change in status or other applicable event if requested. I understand that by making this request, the person(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.

SIGNATURE	DATE	PHONE

Language/Communication Assistance. Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please request assistance by emailing benefits.assistance@tn.gov and FA.CivilRights@tn.gov or calling 800-253-9981. If you think you have been denied free language or communications assistance, please call 615-532-9617 for the F&A Civil Rights Coordinator or follow the F & A complaint procedures in F & A Policy No. 36. Non-Discrimination Policy and Complaint Procedure which is available at the following link: Policy 36 - 10.24.2024 pdf

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

Arabic
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).

Chinese
注意：如果您會說中文，則提供免費的語言協助服務。 請致電 1-866-576-0029（電傳打字機：1-800-848-0298）。

Vietnamese
CHÚ Ý: Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn. Gọi 1-866-576-0029 (TTY: 1-800-848-0298).

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

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1800-848-0298).

Laotian
ຂ້ອນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີຢ່. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

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

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

Gujarati
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).

Japanese
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

Tagalog
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).

Hindi
ध्यान दें: यदि आप ँदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध ै। 1-866-576-0029 (TTY: 1800-848-0298) पर कॉल करें।

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

Persian
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.