



STATE GROUP INSURANCE PROGRAM

DEPENDENT VERIFICATION FACSIMILE TRANSMITTAL SHEET

State of Tennessee • Department of Finance and Administration • Benefits Administration
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Please use this form when submitting dependent verification documents for employees who are sending documents via fax.

To: Benefits Administration

From: _____

Agency: _____

Employee ID: _____

Employee SSN: _____

Name of Employee: _____

Number of Documents: _____

Comments:

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