RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

INSURANCE CANCEL REQUEST APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue • Suite 2600 • Nashville, TN 37243 • Fax: 615.741.8196

PARTNERS FOR HEALTH
FOR EMPLOYEE

Name	Edison ID	Employer Group: ❑ UT ❑ TBR ❑ State ❑ Local Ed ❑ Local Gov

INSTRUCTIONS

You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment transfer period except for one of the following events:

1. If you and/or your dependent(s) become newly eligible for coverage under another plan (**proof is required** and only the individual or individuals who become newly eligible for other coverage may cancel). You have **60 days** from the date that you and/or your dependent(s) become newly eligible for coverage to submit documentation.
2. If enrolled in the prepaid dental option administered by Assurant and there is no participating general dentist within a 40-mile radius of your home.

Please note, the purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordinator.

PART 1 — PARTICIPANT(S) CANCELING COVERAGE (attach a separate sheet if necessary)

I am requesting to cancel ❑ medical ❑ dental coverage on the participant(s) listed below due to:

❑ Becoming newly eligible for other coverage (mark reason in Part 2 below)

❑ Assurant prepaid dental only; no participating general dentist within 40 miles of my home (skip Part 2 below)

❑	Employee	❑	Child (provide name):	
❑	Spouse	❑	Child (provide name):	

PART 2 — REASON PARTICIPANT(S) HAS BECOME NEWLY ELIGIBLE UNDER ANOTHER PLAN

REASON	DOCUMENTATION REQUIRED
❑ Marriage	Copy of marriage certificate
❑ Adoption / placement for adoption	Copy of adoption documents
❑ New employment (self, spouse or dependent)	Letter, on company letterhead, from employer certifying date of eligibility
❑ Return from unpaid leave	Letter, on company letterhead, from employer certifying date of return from unpaid leave
❑ Entitlement to Medicare, Medicaid or TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card
❑ Birth	Copy of birth certificate
❑ Divorce or legal separation	Copy of divorce decree or legal separation paperwork signed by judge
❑ Court decree or order	Copy of court decree or order signed by judge
❑ Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage
❑ A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)	Letter stating date of location change with member's new address
❑ From part-time to full-time employment (spouse or dependent)	Letter, on company letterhead, from employer certifying change in status

PART 3 — REQUESTED COVERAGE END DATE

The coverage end date may either be the last day of the month prior to the eligibility date of other coverage, the last day of the month that the event occurred or the last day of the month that the documentation for cancellation is submitted.	Last day coverage to be active (mm/dd/yy)

PART 4 — AUTHORIZATION

By signing this application, I attest that I and/or my dependent(s) are eligible to cancel coverage either because we have become newly eligible for coverage under another plan or because we are enrolled in the prepaid dental option administered by Assurant and there is no participating general dentist within a 40-mile radius of our home. I further attest that the information I am submitting is true and accurate. I understand that by making this request, the participant(s) whose coverage is canceled will not be eligible for COBRA.

Employee Signature	Date	Phone
Agency Benefits Coordinator Signature	**Date**	**Notes**