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, 19th Floor • Nashville, TN 37243 • 800.253.9981 • fax 615.741.8196

PARTNERS FOR HEALTH

NAME	EDISON ID	EMPLOYER GROUP: ☐ UT ☐ TBR ☐ STATE ☐ LOCAL ED ☐ LOCAL GOV

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

I am requesting to cancel ☐ medical ☐ dental ☐ STD ☐ LTD ☐ vision coverage on the participant(s) listed below due to:

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

☐ Prepaid dental; no participating general dentist within 40 miles of my home (skip Parts 2 and 3 below)

☐ Disability; requires 30 days advance written notice (skip Parts 2 and 3 below)

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

INSTRUCTIONS

You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment period except for one of the following events. (Note: STD and/or LTD may be canceled during the year for any reason.)

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 and there is no participating general dentist within a 40-mile radius of your home. The coverage end date will be the last day of the month that this form is submitted to Benefits Administration.

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

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

REASON	DOCUMENTATION REQUIRED
☐ Marriage	Copy of marriage certificate and proof of other coverage (see #1 above)
☐ Adoption / placement for adoption	Copy of adoption documents and proof of other coverage (see #1 above)
☐ 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 and proof of other coverage (see #1 above)
☐ Divorce or legal separation	Copy of divorce decree or legal separation paperwork signed by judge and proof of other coverage (see #1 above)
☐ 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
☐ Marketplace Enrollment	I attest that I am enrolled or intend to enroll in the Marketplace

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 or the last day of the month that the event occurred.	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 Cigna and there is no participating general dentist within a 40-mile radius of our home. I also attest that I can cancel disability coverage for any reason. 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