STATE OF TENNESSEE GROUP INSURANCE PROGRAM

OPTIONAL ACCIDENTAL DEATH ENROLLMENT APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
19th Floor, 312 Rosa L. Parks Avenue • Nashville, Tennessee 37243 • 615.741.3590 or 800.253.9981

TYPE OF REQUEST	ACTION FOR ENROLLMENT CHANGE
❑ New Enrollment ❑ Employee only ❑ Employee + dependents ❑ Enrollment Change	❑ Add Dependent ❑ Terminate Dependent ❑ Update Dependent Eligibility ❑ Terminate Coverage ❑ Add/Change Beneficiary ❑ Change Coverage Type to: ❑ Single ❑ Family Effective Date of Change: _____

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

DEPENDENT INFORMATION

Name (First, MI, Last)	Date of Birth	Relationship	Gender	Acquire date *	Social Security Number
			❑ M ❑ F		
			❑ M ❑ F		
			❑ M ❑ F		
			❑ M ❑ F		

* **The acquire date is the date of marriage, birth, adoption or guardianship.**
Proof of a dependent's eligibility must be submitted with this application for all new dependents.

AUTHORIZATION

I confirm that all the above information is accurate. I understand that providing false and/or misleading information may subject me to disciplinary and/or legal action. I authorize my employer to deduct the required premium from my salary/wages.

I authorize the state group insurance program to release information to their life insurance contractor on behalf of myself and all family members (name, address, social security number, age, gender, salary, enrollment effective/termination date) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The state group insurance program 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 understand that a new application must be completed and returned to my agency benefits coordinator any time I want to designate a new beneficiary. Failure to designate a beneficiary will result in the proceeds being paid to my spouse, children, parents or estate according to applicable contract provisions in the event of my death. Dependents do not elect a beneficiary as the benefit will automatically default to me as the employee.

_____ _____

Employee Signature Date

Complete beneficiary designation on back of this application and return to your agency benefits coordinator

Name	Edison ID	OR	SSN

PRIMARY BENEFICIARY DESIGNATION

Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Total for Primary Beneficiary (must be 100%)				**Total**

CONTINGENT BENEFICIARY DESIGNATION

Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Name	Phone Number	Social Security Number	Relationship	Percent of Benefit
Home Address		City	State	Zip Code
Total for Contingent Beneficiary (must be 100%)				**Total**

NOTE: Contingent beneficiary will only receive benefits if all primary beneficiaries are deceased.