RESET

STATE GROUP INSURANCE PROGRAM

OPTIONAL SPECIAL ACCIDENT ENROLLMENT APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
26th Floor WRS TN Tower • 312 Rosa Parks Ave • Nashville, TN 37243 • 615.741.3590 • 1.800.253.9981 • Fax 615.741.8196

TYPE OF REQUEST

- ❑ New Enrollment
  - ❑ Single
  - ❑ Family
- ❑ Enrollment Change

ACTION FOR ENROLLMENT CHANGE

- ❑ Add Dependent
- ❑ Terminate Dependent
- ❑ Update Dependent Eligibility
- ❑ Terminate Coverage
- ❑ Change Beneficiary
- ❑ Change Coverage Type to: ❑ Single ❑ Family

Effective Date of Change: _____

EMPLOYEE INFORMATION

Name		Social Security Number	EmplID (if known)
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Daytime Phone	Gender ❑ M ❑ F	Date of Birth
Employing Agency Volunteer State Community College	Budget Code/Dept ID	Annual Salary	Date of Hire
Home Address	City	State	Zip Code

DEPENDENT INFORMATION

Social Security Number	Name Last, First, MI	Birth Date mm/dd/yy	Relationship Code	Relationship as of date	Gender	Full-Time Student
					❑ M ❑ F	❑ Y ❑ N
					❑ M ❑ F	❑ Y ❑ N
					❑ M ❑ F	❑ Y ❑ N
					❑ M ❑ F	❑ Y ❑ N

Relationship Codes: SP – legally married spouse; CN – natural or adopted child; CS – stepchild; CL – legal guardian; CT – IRS tax dependent

PRIMARY BENEFICIARY

Name	Social Security Number	Relationship	
Home Address	City	State	Zip Code

CONTINGENT BENEFICIARY

Name	Social Security Number	Relationship	
Home Address	City	State	Zip Code

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.

Employee Signature _____ Date _____

Return this form to your agency benefits coordinator

Coverage administered by Fort Dearborn Life Insurance Company