STATE OF TENNESSEE GROUP INSURANCE PROGRAM

FLEXIBLE BENEFITS PLAN ENROLLMENT- PLAN YEAR 2026

Complete this form only if you wish to participate in the Medical, Limited Purpose or Dependent Care Reimbursement Account

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

HOME ADDRESS	CITY	STATE	ZIP CODE

DEPARTMENT NAME	DEPT ID / BUDGET CODE	DATE HIRED	EMPLOYEE ID (IF KNOWN)

WORK PHONE	PAYROLL FREQUENCY (PAYCHECKS PER YEAR)	ENROLLMENT STATUS
	❑ 12 ❑ 24 ❑ Other ____	❑ New Hire

REIMBURSEMENT ACCOUNT ENROLLMENT (new elections must be filed each year)

Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact your HR office for additional information.

If you are enrolled in the HealthSavings CDHP, you are not eligible to contribute to the Medical Expense Account; however, you may contribute to the Limited Purpose Account (for vision and/or dental expenses only).

In Box #1, indicate the reduction amount per pay period. In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year. Consult your payroll office if you are unsure of how many checks you will receive. In Box #3, indicate the total dollar amount you elect to contribute for the plan year.

MEDICAL EXPENSE ACCOUNT	LIMITED PURPOSE ACCOUNT	DEPENDENT CARE ACCOUNT
Maximum allowable annual contribution is $3300	Maximum allowable annual contribution is $3300	Tax Filing Status (please check one) O Married, filing separately (maximum $3,750) O Married, filing jointly (Maximum $7,500 O Head of household (maximum $5,000)
Box #1 Reduction per regular paycheck:	Box #1 Reduction per regular paycheck:	Box #1 Reduction per regular paycheck:
Box #2 Number of regular paychecks expected: X	Box #2 Number of regular paychecks expected: X	Box #2 Number of regular paychecks expected: X
Box #3 Total plan year dollar amount: = $0.00	Box #3 Total plan year dollar amount: = $0.00	Box #3 Total plan year dollar amount: = $0.00

AUTHORIZATION

- I understand this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- I hereby authorize my employer to reduce my gross salary before federal, state and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file an approved family status change.
- I understand that any amount remaining in my Dependent Care account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year. I also understand that any funds in excess of $500 remaining in either the Medical Expense Account or Limited Purpose Account at the end of the year will be forfeited. Funds of $640 or less will carry over into the following year if I re-enroll.
- I understand and agree that the state will not incur any liability resulting from either my participation in or my failure to accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I forego my right to participate during the upcoming plan year.

EMPLOYEE SIGNATURE	DATE

Return this application to your human resource office after making a copy for your records.
For questions regarding reimbursement requests, please call TASC