



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**  
 FOR RETIREE

NAME	SSN OR EDISON ID
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**PART 1 — PARTICIPANT(S) CANCELING COVERAGE (ATTACH A SEPARATE SHEET IF NECESSARY)**

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

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

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

<input type="checkbox"/> Retiree	<input type="checkbox"/> Child (provide name):	
<input type="checkbox"/> Spouse	<input type="checkbox"/> 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:

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/effective date of coverage 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 Benefits Administration..

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

REASON	DOCUMENTATION REQUIRED
<input type="checkbox"/> Marriage	Copy of marriage certificate and proof of other coverage (see #1 above)
<input type="checkbox"/> Adoption / placement for adoption	Copy of adoption documents and proof of other coverage (see #1 above)
<input type="checkbox"/> New employment (self, spouse or dependent)	Letter, on company letterhead, from employer certifying date of eligibility/enrollment
<input type="checkbox"/> Entitlement to Medicare, Medicaid or TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card
<input type="checkbox"/> Birth	Copy of birth certificate and proof of other coverage (see #1 above)
<input type="checkbox"/> Divorce or legal separation	Copy of divorce decree or legal separation paperwork signed by judge and proof of other coverage (see #1 above)
<input type="checkbox"/> Court decree or order	Copy of court decree or order signed by judge
<input type="checkbox"/> Open enrollment	Letter, on company letterhead, certifying date of eligibility/enrollment for other coverage
<input type="checkbox"/> A change in your place of residence 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
<input type="checkbox"/> From part-time to full-time employment (self, spouse or dependent)	Letter, on company letterhead, from employer certifying change in status
<input type="checkbox"/> 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)
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**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 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.

SIGNATURE	DATE	PHONE	EMAIL ADDRESS
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