STATE OF TENNESSEE GROUP INSURANCE PROGRAM

FLEXIBLE BENEFITS PLAN ENROLLMENT FOR ANNUAL ENROLLMENT AND NEWLY ELIGIBLE EMPLOYEES— PLAN YEAR 2026

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

This is NOT an application for insurance. To enroll or change medical or dental insurance you must complete the proper insurance enrollment form.

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)

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

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 or you may call Benefits Administration at 615.741.3590 or 800.253.9981.

If you are enrolled in the CDHP/HSA, 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

Maximum allowable annual contribution is $3,300

Box #1 Reduction per regular paycheck		
Box #2 Number of regular paychecks expected	X	
Box #3 Total plan year dollar amount	=	$0.00

LIMITED PURPOSE ACCOUNT

Maximum allowable annual contribution is $3,300

Box #1 Reduction per regular paycheck		
Box #2 Number of regular paychecks expected	X	
Box #3 Total plan year dollar amount	=	$0.00

DEPENDENT CARE ACCOUNT

Tax Filing Status (please check one)

❑ Married, filing separately (maximum $3,750)
❑ Married, filing jointly (maximum $7,500)
❑ Head of household (maximum $7,500)

Box #1 Reduction per regular paycheck		
Box #2 Number of regular paychecks expected	X	
Box #3 Total plan year dollar amount	=	$0.00

See page 2 to complete and sign this Flexible Benefits enrollment form.

AUTHORIZATION

- I confirm that the information above is true.
- 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 for the current plan year (to include termination of employment) unless I file an approved request for a mid-year change due to a status change event.
- I understand that any amount remaining in my Dependent Care FSA 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 $660 remaining in either the General Medical FSA or Limited Purpose FSA at the end of the year will be forfeited. Funds of $660 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 a flexible benefit or from 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.
- I understand that if I terminate employment during the plan year, I have 90 days from my termination date to submit claims for eligible expenses and that any claims submitted for reimbursement must be for dates of service on or prior to my termination date. Any funds left in my account(s) after the 90 days are forfeited.
- I acknowledge that FSA funds may only be spent on certain expenses. Medical Flexible Spending Account (FSA) and Limited Flexible Spending Account (L-FSA) debit card holders may be required to provide proof that expenses paid for with their debit card are covered expenses permitted by federal law and the FSA program. This is called "substantiation." The State's authorized contractor may send requests for substantiation to plan members.
- When a debit card expense is not substantiated, employers are required to recover the unsubstantiated expense through a number of mechanisms, including payroll deduction. FSA and L-FSA debit card holders must consent to payroll deductions from their wages to repay unsubstantiated expenses. Anyone who refuses to consent to these terms will not be allowed to enroll in the FSA or L-FSA.
- If I enroll in a Health FSA, I hereby agree that the State may deduct from my pay the amount of any expenses that remain unsubstantiated at the end of the runout period to the extent permitted by applicable law. This authorization of payroll deduction is a condition to participate in an FSA or L-FSA.

EMPLOYEE SIGNATURE	DATE

Return this application to your human resource office after making a copy for your records.
For questions regarding enrollment or a status change event, please call Benefits Administration at 615.741.3590 or 800.253.9981.
For questions regarding reimbursement requests, please call Optum Bank at 866.600.4984.

Language/Communication Assistance. Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please request assistance by emailing benefits.assistance@tn.gov and FA.CivilRights@tn.gov or calling 800-253-9981. If you think you have been denied free language or communications assistance, please call 615-532-9617 for the F&A Civil Rights Coordinator or follow the F & A complaint procedures in F & A Policy No. 36. Non-Discrimination Policy and Complaint Procedure which is available at the following link: Policy 36 - 10.24.2024 pdf

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298)

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-576-0029 (رقم هاتف الصم والبكم: 1-800-848-0298).

Chinese
注意：如果您會說中文，則提供免費的語言協助服務。 請致電 1-866-576-0029（電傳打字機：1-800-848-0298）。

Vietnamese
CHÚ Ý: Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn. Gọi 1-866-576-0029 (TTY: 1-800-848-0298).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0029)번으로 전화해 주십시오.

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1800-848-0298).

Laotian
ຂ້ຄວນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີຢ່. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-576-0029 (TTY: 1-800-848-0298).

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY: 1-800-848-0298).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

Hindi
ध्यान दें: यदि आप ँदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध ै। 1-866-576-0029 (TTY: 1800-848-0298) पर कॉल करें।

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

Persian
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-576-0029 (TTY: 1-800-848-0298) تماس بگیرید.

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT ENROLLMENT APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

TYPE OF REQUEST	ACTION FOR ENROLLMENT CHANGE	EMPLOYEE VOLUME OF COVERAGE
❑ New Enrollment/Change ❑ Employee only ❑ Employee + spouse ❑ Employee + spouse + child(ren) ❑ Employee + child(ren) ❑ Other Enrollment*	❑ Add Dependent ❑ Terminate Dependent ❑ Terminate Coverage ❑ Add/Change Beneficiary Effective Date of Change: _____	❑ $50,000 ❑ $60,000 ❑ $100,000 ❑ $250,000 ❑ $500,000 (The volume of coverage options are for the employee. Dependent coverage values, if chosen, will be a percentage of the employee's value.)

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**	SSN

❑ A separate sheet with more dependents is attached

AUTHORIZATION

I understand this enrollment is only for voluntary AD&D coverage and that it us up to me as the employee to designate a beneficiary. I further understand that I can only change my beneficiary designation(s) in Edison or by completing a new application and returning it to my agency benefits coordinator. If I fail to designate a beneficiary, I understand, that in the event of my death, proceeds will be paid to my spouse, children, parents, or estate according to applicable certificate of coverage provisions.

I authorize the State Group Insurance Program to release information to its life insurance contractor on behalf of myself and all family members required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force while I have a pending application or maintain enrollment with the SGIP's life insurance company. The SGIP 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 confirm that all information I have provided herein is accurate and that I may be subject to disciplinary and/or legal action if I provide false and/or misleading information. I authorize my employer to deduct the required premium from my salary/wages.

_____ _____

EMPLOYEE SIGNATURE DATE

AGENCY SECTION – MUST BE COMPLETED BY AGENCY BENEFITS COORDINATOR

HIRE DATE	ABC SIGNATURE/DATE

Complete beneficiary designation on page 2 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.