



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT ENROLLMENT APPLICATION

University of Tennessee • Payroll, Benefits and Retirement • Benefits Administration
505 Summer Place - UT Tower 907 • Knoxville, TN 37902 • 865.974.5251 • utinsurance@tennessee.edu

Form section with three columns: TYPE OF REQUEST, ACTION FOR ENROLLMENT CHANGE, and EMPLOYEE VOLUME OF COVERAGE. Includes checkboxes for enrollment types and coverage amounts.

EMPLOYEE INFORMATION section with fields for FIRST NAME, MI, LAST NAME, DATE OF BIRTH, GENDER, MARITAL STATUS, SOCIAL SECURITY NUMBER, EMPLOYING AGENCY, DAYTIME PHONE NUMBER, EDISON ID, HOME ADDRESS, CITY, ST, and ZIP CODE.

DEPENDENT INFORMATION section with a table for Name (First, MI, Last), Date of birth, Relationship, Gender, Acquire date**, and SSN.

Check box: A separate sheet with more dependents is attached

AUTHORIZATION section containing a declaration of understanding, an authorization statement, and a confirmation statement, followed by signature and date lines.

AGENCY SECTION - MUST BE COMPLETED BY AGENCY BENEFITS COORDINATOR. Includes fields for HIRE DATE and 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.

**Reliance Standard Life Insurance Company
Enrollment and Statement of Health**

Name of Employer The University of Tennessee		Location/Division 01		Bill Group 000001
Policy # and Class # LTD134277 / 01	Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #

Application Type: Initial Eligibility/New Hire Late Applicant Other _____
 Increase Approved Annual Enrollment
 Change in Status: Nature of Change(s): _____

Date of Change: _____
 If marriage, domestic partnership, divorce, dissolution of a partnership or birth of a child, please provide copy of document.

Employee/Member Information – Always Complete

Submit completed Enrollment and Statement of Health form to:
EOApplications@rsl.com or

**Reliance Standard
P.O. Box 7818
Philadelphia, PA 19101-7818**

We do not accept faxed forms.

Name		Social Security Number/Employee ID		
Gender	Date of Birth	Age	State of Birth	Date of Hire
Address		City	State	Zip
Phone Number	Occupation	Annual Compensation	Hours Worked Per Week	
Email Address				

Are you actively performing all the duties of your occupation or profession? Yes No

If "No," explain: _____

Coverage Elected and Amounts

Coverage	Enroll or Decline ¹	Current Amount	Increase or Decrease	Total Amount Applied For	Monthly Premium
Voluntary LTD: Employee²	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> 66.67% of Earnings to \$8,000 max.	See Premium Table

¹"Earnings" as used above refers to "Covered Earnings" as defined in the applicable Policy.

²"Enroll" authorizes employer to payroll deduct premiums.

³Statement of Health may be required.

Premium Calculation Table

Monthly Earnings*: \$ _____

Multiply by rate: x .00149

Equals Monthly Premium: \$ _____

*If your monthly salary exceeds \$11,999, use \$11,999 multiplied by .00149.



2023

The University of Tennessee

Employee Authorization for Payroll Deduction to Health Savings Account

Use this form to have money withheld from your paychecks and deposited into your health savings account (HSA) on a pre-tax basis.

You must be enrolled in a consumer-driven health plan (CDHP) with a HSA before you can start a payroll deduction.

I wish to:		
<input type="checkbox"/> Begin a deduction <input type="checkbox"/> Change my deduction <input type="checkbox"/> Stop my deduction		Effective date _____
Section 1: Employee Information		
Name _____ <i>(Last, First, Middle initial)</i>	Personnel Number _____ Work phone number _____	
Section 2: Calculate Your Maximum HSA Contribution		
Use the worksheet below to determine how much you can contribute to your HSA in 2023.		
	Select your enrollment status	
	Individual HSA	Family HSA
A. Maximum amount that can be put in your HSA for 2023	\$3,850	\$7,750
B. Are you age 55 or older? No , write \$0. Yes , write \$1,000	+	+
C. How much your employer will contribute in 2023	- \$ 500-	- \$1,000-
D. A + B - C = <i>The most you can contribute in 2023</i>	=	=
If your contributions exceed the amount in D, you risk paying IRS tax penalties. If you are submitting a mid-year change, be sure to include any amounts you have already contributed in 2023.		
Section 3: Calculate Your Per-Paycheck HSA Contribution		
<i>Continue the worksheet to determine how much you will contribute to your HSA per paycheck.</i>		
Individual HSA	Family HSA	
Total from D. \$ _____	Total from D. \$ _____	
E. Number of paychecks remaining in 2023 _____ (if paid biweekly max is 24)	E. Number of paychecks remaining in 2023 _____ (if paid biweekly max is 24)	
F. $D \div E =$ \$ _____ <i>This is the most you can contribute per paycheck (You can preload and use more but you must complete a second form stopping the larger contribution)</i>	F. $D \div E =$ \$ _____ <i>This is the most you can contribute per paycheck (You can preload and put more, but you must complete a second form stopping the larger contribution)</i>	
Amount you elect to contribute to your HSA per paycheck \$ _____ <i>Can be any amount up to or less than F</i>	Amount you elect to contribute to your HSA per paycheck \$ _____ <i>Can be any amount up to or less than F</i>	
<i>Instead of a year long payroll deduction you also have the option to "front load" your HSA account and then stop deductions after you reach the IRS max. (ex: elect four (4), \$962.50 deductions during the beginning of the year and then stop the deduction.)</i>		
By signing this form, I am requesting that payroll deductions be started or changed as shown in Section 3 above and agree to the preceding terms. I understand there are maximum limits I can contribute to my HSA per IRS rules and I may be liable for tax penalties if I exceed this amount. This request replaces any previous payroll deduction requests for my HSA.		
Employee's signature	Date	

Return this form to 505 Summer Place - 937 UT Tower • Knoxville, Tennessee 37902 •
(865) 974-5251 • payroll@tennessee.edu Keep a copy for your records.



FSA ELECTION & COMPENSATION REDUCTION AGREEMENT — 2023 PLAN YEAR

University of Tennessee • Payroll, Benefits and Retirement • Flexible Benefits Administration
 505 Summer Place - UT Tower 907 • Knoxville, TN 37902 • 865.974.5251 • utinsurance@tennessee.edu

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	PER NO (FRM EMP ID CARD)
HOME ADDRESS	CITY	STATE	ZIP CODE
DEPARTMENT NAME		DATE OF EMPLOYMENT	EFF DATE FOR DEDUCTION
WORK PHONE	PAYROLL FREQUENCY (PAYCHECKS PER YEAR) BI-WEEKLY MONTHLY	ENROLLMENT STATUS <input type="checkbox"/> New Hire <input type="checkbox"/> Change	

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 the Payroll office for additional information at 865-974-5251 or utinsurance@tennessee.edu

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 for 2023 is \$2,850		ONLY TO BE USED WITH AN EXISTING HSA ACCOUNT AND THE CDHP HEALTH OPTION Maximum allowable annual contribution is \$2,850		Tax Filing Status (please check one) <input type="checkbox"/> Married, filing separately (maximum \$2,500) <input type="checkbox"/> Married, filing jointly (maximum \$5,000) <input type="checkbox"/> 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 reg. paychecks (remaining)	X	Box #2 Number of reg. paychecks (remaining)	X	Box #2 Number of reg. paychecks (remaining)	X
Box #3 Total plan year dollar amount	= \$	Box #3 Total plan year dollar amount	= \$	Box #3 Total plan year dollar amount	= \$

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 \$570 remaining in either the Medical Expense Account or Limited Purpose Account at the end of the year will be forfeited. Funds of \$570 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
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Return this application to The University of Tennessee Benefits Office, 505 Summer Place - UT Tower 907, Knoxville, TN 37902
 For questions regarding enrollment or a family status change, please contact the Benefits Office 865.974.5251