

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

TYPE OF REQUEST				ACTION	OD ENDO	NI LAMENIT	CHAN	CF		EMPLOYEE N	1011	IME OF COVERACE
TYPE OF REQUEST			5	ACTION F		PLLMENT	CHAN	GE		i.		ME OF COVERAGE
New Enrollment/Change				Add Dependent				\$50,000	,	The volume of overage options are		
☐ Employee only				Termina	•					\$60,000		or the employee.
☐ Employee + spouse				Termina		-				\$100,000		ependent coverage alues, if chosen, will
☐ Employee + spouse		n)		☐ Add/Ch	iange Ben	eficiary				\$250,000	b	e a percentage of the
■ Employee + child(re	en)			Effective Da	ate of Cha	nge:			-00	\$500,000	eı	mployee's value.)
☐ Special Enrollment*												
EMPLOYEE INFORMATION OF THE STREET NAME	ON	МІ	ΙΔSΤ	NAME			DATEO	F BIRTH	GF	ENDER	ΜΔΡ	ITAL STATUS
THIST NAME		"	LAST	NAIVIE DATE C								
	1											
SOCIAL SECURITY NUMBER	EMPLOYII	NG AGENO	Υ	DAYTIME PHONE NU			IUMI	JMBER EDISON		ON ID (if known)		
HOME ADDRESS					CITY		-	ST			ZIP CODE	
DEPENDENT INFORMAT	ION										V	
Name (First, MI, Last)	ION	Date of b	oirth	Relation	nship			Gender	Ac	quire date**		SSN
				-								
									_			
A separate sheet with r	more dene	ndents is	attach	ned .					-			
- A separate sheet with	nore depe	ildelits is	attaci									
AUTHORIZATION												
I understand this enrollme	nt is only fo	or volunta	arv AD	&D coverage	and that	it us up to	me as tl	ne emplov	ee to	o designate a be	enefici	arv. I further
understand that I can only	change my	y benefici	ary de	signation(s)	in Edison	or by com	pleting a	new appl	licati	ion and returnin	ıg it to	my agency benefits
coordinator. If I fail to desig					n the ever	nt of my de	eath, pro	ceeds will	be p	oaid to my spou	se, chi	ildren, parents, or
estate according to applica	ble certific	ate of co	verage	provisions.								
I authorize the State Group												
required to establish eligib a pending application or m												
eligibility on the signature												
I confirm that all information	n I have p	rovided h	erein i	is accurate aı	nd that I m	nay be sub	ject to d	lisciplinary	and	d/or legal action	if I pro	ovide false and/or
misleading information. I a										3		
EMPLOYEE SIGNATURE						_		ATE				
AGENCY SECTION - MU	ST BE CO	MPLETE	D BY	AGENCY B	ENEFITS	COORDI	NATOR					
HIRE DATE		ABC SIG	NATUF	RE/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%) CONTINGENT BENEFICIARY DESIGNATION				TOTAL
	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	
CONTINGENT BENEFICIARY DESIGNATION	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	
CONTINGENT BENEFICIARY DESIGNATION NAME	PHONE NUMBER PHONE NUMBER		STATE	PERCENT OF BENEFIT ZIP CODE
CONTINGENT BENEFICIARY DESIGNATION NAME HOME ADDRESS		CITY	STATE	PERCENT OF BENEFIT ZIP CODE
CONTINGENT BENEFICIARY DESIGNATION NAME HOME ADDRESS NAME		CITY SOCIAL SECURITY NUMBER	STATE RELATIONSHIP STATE	PERCENT OF BENEFIT ZIP CODE PERCENT OF BENEFIT
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Reliance Standard Life Insurance Company Enrollment and Statement of Health

Enrollment ar	iu Stat	ement of nealtr	1							
Name of Employer The University of Tennessee				L	Division			Bill Group 000001		
Policy # and Class : LTD134277 / 01	#	Policy # and Class #	Policy	# and Class #	Р	Policy # and Class # P		Policy	# and Class #	
Application Type:	□ Incr		y/New Hire Late Applicant Other 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/Men	nber Inf	ormation – Alway	s Complete							
Submit completed and Statement of H						Social Security Numb		ity Numbe	er/Employee ID	
to: EOIApplications@rs	sli.com or	Gender	Date	Date of Birth		State of Birth			Date of Hire	
Reliance Standard	t	Address				City		State	Zip	
P.O. Box 7818 Philadelphia, PA 19101-7818			'	Occupation		Annual Compensation Hours V		Hours Wo	orked Per Week	
We do not accept faxed forms.										
	rforming a	II the duties of your oc	ccupation or pro	fession? 🗆 Ye	es 🗆 No	0				
If "No," explain:										
Coverage Elect	ed and	Amounts								
Coverage		Enroll or Decline ¹	Current Amount	Increase or Decrease		Total Amoun	nt Applied Fo	or	Monthly Premium	
Voluntary LTD: En		☐ Enroll ☐ Decline			□ 66.	67% of Earnin	gs to \$8,000	max.	See Premium Table	
"Earnings" as used above 1"Enroll" authorizes emplo 2Statement of Health may	oyer to payro		d in the applicable f	Policy.						
Premium Calculation Tab	<u>ole</u>									
Monthly Earnings*:	\$									
Multiply by rate:	x .00149									
Equals Monthly Premium	ı: \$									

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

Read, Sign and Date Below

I understand and agree that:

- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
- Benefits are subject to terms and conditions of the Policy.
- For age-banded rate plans, premiums increase as an employee moves from one age band to the next.
- If payroll deduction of premiums begins prior to Reliance Standard's processing of the enrollment form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of "Important Information Regarding Applications for Insurance" and "Notice Regarding Information Practices".

Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself; or b) during your present service with your employer or an affiliate, you have not, with respect to insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.

X	 Date

LRS-9457-0118



The University of Tennessee

2023

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: Begin a deduction Change my deduction Stop my deduction Effective date								
Section 1: Employee Information								
Name(Last, First, Middle initial)	Personnel 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 \$1,0	00	+	+					
C. How much your employer will contribute in 2023		- \$ 500-	- \$1,000-					
D. A + B – C =		=	=					
The most you can contribute in 2023 If your contributions exceed the amount in D, you risk paying	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 Continue the worksheet to determine how much you will contribute to your HSA per paycheck.								
Individual HSA	Family HS	A						
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 ÷ E = \$ 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)	D ÷ E = \$is the most you can contribute per paycheck can preload and put more, but you must complete a nd form stopping the larger contribution)							
Amount you elect to contribute to your HSA per paycheck \$ Can be any amount up to or less than F Amount you elect to contribute to your HSA per paycheck \$ Can be any amount up to or less than F								
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.)								
and agree to the preceding terms. I understand there are and I may be liable for tax per	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.							
I his request replaces any previous pa	ayroli 0	Date Date	noa.					
Employee o digitatal o		Date						

UNIVERSITY OF TENNESSEE FLEXIBLE BENEFITS PLAN



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	EMP ID CARD)		
HOME ADDRESS			CITY	1	STATE	ZIP CODE		
DEPARTMENT NAME				-	DATE OF EMPLOYMENT	EFF DATE FO	R DEDUCTION	
WORK BLIONE		DAVIDOLI EDEGLIENCY	(DAVCHECKE DE	D \/E A D)	ENROLLMENT STATUS			
WORK PHONE	PAYROLL FREQUENCY		,	New Hire Change				
		BI-WEEKLY	MONTHLY	<u></u>	inew nife Change			
REIMBURSEMENT ACCOUNT EN								
Indicate the amount you wish to con						e sections belo	ow. If you	
have questions, contact the Payroll of	iffice for addi	itional information at 8	305-9/4-5251 Or	utinsurance	<u>øtennessee.eau</u>			
If you are enrolled in the HealthSavin	-		ntribute to the N	∕ledical Exper	nse Account; however, yo	ou may contrib	oute to the	
Limited Purpose Account (for vision a								
In Box #1, indicate the reduction amount plan year. Consult your payroll office								
contribute for the plan year.	ii you are un	isure of now many che	cks you will rece	ive. In box #3	, indicate the total dolla	r amount you	elect to	
MEDICAL EXPENSE ACCOUNT		LIMITED PURPOS	E ACCOUNT		DEPENDENT CARE	ACCOUNT		
Maximum allowable ann	ual	ONLY TO BE USE	D WITH AN FXIS	TING HSA	Tax Filing Status (please check one)			
contribution for 2023 is \$2	2,850	ACCOUNT AND T			Married, filing separately (maximum \$2,500)			
		Maximum allowable			Married, filing jointly (maximum \$5,000)			
		annuai coi	ntribution is \$2,8	350	Head of household	d (maximum \$	5,000)	
Box #1		Box #1			Box #1			
Reduction per regular paycheck	\$	Reduction per regular pay	/check	\$	Reduction per regular paych	ieck	\$	
Box #2 X		Box #2	х		Box #2	х		
Number of reg. paychecks (remaining)		Number of reg. paychecks	s (remaining)		Number of reg. paychecks (r	emaining) ^		
Box #3 =	ا خ	Box #3	. =	\$	Box #3	. =	\$	
Total plan year dollar amount	\$	Total plan year dollar amo	ount		Total plan year dollar amour	ıt		
AUTHORIZATION								
• I understand this is not an applicati			-					
I hereby authorize my employer to		•		-	•			
salary reduction indicated above. I unless I file an approved family stat		that the amount of sala	ary reduction wi	Il include the	items specified above a	nd will continu	ue in effect	
I understand that any amount remainstance	_	Dependent Care accou	unt that is not us	sed during th	e plan vear will be forfei	ted since it car	nnot be	
carried to the next plan year. I also		•		_				
Account at the end of the year will	be forfeited.	Funds of \$570 or less v	will carry over in	to the follow	ing year if I re-enroll.			
• I understand and agree that the sta		· ·	-					
enrollment form. I further understa		lect not to participate i	n salary reduction	on with respe	ct to the benefits listed	above, I forego	my right to	
participate during the upcoming p	ian year.		1	DATE				
EMPLOYEE SIGNATURE				DATE				

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