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 FOR ENROLLMENT CHANGE	EMPLOYEE VOLUME OF COVERAGE
❑ New Enrollment/Change ❑ Employee only ❑ Employee + spouse ❑ Employee + spouse + child(ren) ❑ Employee + child(ren) ❑ Special 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 (if known)

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.

2024

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:

☐ **Begin** a deduction ☐ **Change** my deduction ☐ **Stop** my deduction Effective date_____

Section 1: Employee Information

Name_____
(*Last, First, Middle initial*)

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 2024.

	Select your enrollment status	
	Individual HSA	**Family HSA**
A. Maximum amount that can be put in your HSA for 2024	$4,150	$8,300
B. Are you age 55 or older? **No**, write $0. **Yes,** write $1,000	+	+
C. How much your employer will contribute in 2024	- $ 500-	- $1,000-
D. A + B – C = *The **most** you can contribute in 2024*	=	=

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 2024.

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 HSA**
Total from D. $_____	Total from D. $_____
E. Number of paychecks remaining in 2024 _____ (if paid biweekly max is 24)	E. Number of paychecks remaining in 2024 _____ (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)*	F. D ÷ E = $ _____ *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)*
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), $1,037.50 deductions during the beginning of the year and then stop the deduction.)

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 - 907 UT Tower • Knoxville, Tennessee 37902 •

(865) 974-5251 • utinsurance@tennessee.edu **Keep a copy for your records.**

RESET

UNIVERSITY OF TENNESSEE FLEXIBLE BENEFITS PLAN

FSA ELECTION & COMPENSATION REDUCTION AGREEMENT — 2024 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)	ENROLLMENT STATUS
	☐ BI-WEEKLY ☐ MONTHLY	☐ New Hire ☐ 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

Maximum allowable annual contribution for 2024 is $3,050 (Minimum contribution for the year is $120)

Box #1 Reduction per regular paycheck		$
Box #2 Number of reg. paychecks (remaining)	X	
Box #3 Total plan year dollar amount	=	$

LIMITED PURPOSE ACCOUNT

ONLY TO BE USED WITH AN EXISTING HSA ACCOUNT AND THE CDHP HEALTH OPTION
Maximum allowable annual contribution is $3,050 (Minimum contribution for the year is $120)

Box #1 Reduction per regular paycheck		$
Box #2 Number of reg. paychecks (remaining)	X	
Box #3 Total plan year dollar amount	=	$

DEPENDENT CARE ACCOUNT

Tax Filing Status (please check one)

☐ Married, filing separately (maximum $2,500)
☐ Married, filing jointly (maximum $5,000)
☐ Head of household (maximum $5,000)

Box #1 Reduction per regular paycheck		$
Box #2 Number of reg. paychecks (remaining)	X	
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 $610 remaining in either the Medical Expense Account or Limited Purpose Account at the end of the year will be forfeited. Funds of $610 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 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

(rev 9/22)