



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

OPTIONAL ACCIDENTAL DEATH ENROLLMENT APPLICATION

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

TYPE OF REQUEST: New Enrollment, Enrollment Change, etc. ACTION FOR ENROLLMENT CHANGE: Add/Remove Dependents, Terminate Coverage, etc. Effective Date of Change: _____

EMPLOYEE INFORMATION: 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, ZIP Code

DEPENDENT INFORMATION: Table with columns for Name (First, MI, Last), Date of Birth, Relationship, Gender, Acquire date, Social Security Number

* The acquire date is the date of marriage, birth, adoption or guardianship. Proof of a dependent's eligibility must be submitted with this application for all new dependents.

AUTHORIZATION: I confirm that all the above information is accurate. I understand that providing false and/or misleading information may subject me to disciplinary and/or legal action. I authorize my employer to deduct the required premium from my salary/wages. I authorize the state group insurance program to release information to their life insurance contractor on behalf of myself and all family members... I understand that a new application must be completed and returned to my agency benefits coordinator any time I want to designate a new beneficiary. Failure to designate a beneficiary will result in the proceeds being paid to my spouse, children, parents or estate according to applicable contract provisions in the event of my death. Dependents do not elect a beneficiary as the benefit will automatically default to me as the employee.

Complete beneficiary designation on back of this application and return to your agency benefits coordinator

Name	Edison ID	OR	SSN
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PRIMARY BENEFICIARY DESIGNATION

Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	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	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	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.