Benefit Enrollment Checklist

Name: _____ Personnel #/UTC ID: _____

Department: _____ Hire date: _____

Please select one: Enrollment deadline: _____

☐ Exempt (monthly salary)

☐ Non-exempt (hourly, paid biweekly)

Do you have prior State of Tennessee service?
If yes, please give name of institution and approximate dates:

_____

To be completed by Human Resources:

Retirement forms for *exempt* employees: Sent to UT Retirement: _____

☐ Notice of Election to Participate in ORP or TCRS

☐ Premium Distribution Specification Form

(*Required if electing ORP. Must confirm TIAA / Voya account is open.)*

Required Insurance forms: Sent to UT Insurance: _____

☐ Enrollment Change Application *(Carrier networks and family tiers must be selected)*

- ☐ Health: Premier PPO, Standard PPO, or CDHP/HSA
- ☐ Dental: Delta DPPO or Cigna DHMO
- ☐ Vision: Basic or Expanded
- ☐ Short-term Disability: 14-day or 30-day elimination (waiting) period
- ☐ Long-Term Disability: **Automatic enrollment for some LTD coverage.* Employee to confirm employer-paid or employee-paid option.

☐ Basic Term Life/AD&D Enrollment Application *(Automatic, State-paid enrollment)*

- ☐ Full coverage: 1x annual base salary - $50,000 minimum to $250,000 maximum (*default option*)
- ☐ Coverage capped at $50,000

☐ Proof of dependent eligibility if anything other than employee-only coverage is selected

Optional Insurance forms:

☐ Voluntary AD&D *(Volume of Coverage must be selected)*

☐ HSA Payroll deduction form

☐ FSA Election and Compensation Reduction Agreement

☐ 403(b) Salary Reduction Form (*Must confirm TIAA / Voya account is open.)*

Online Enrollment Reminders:

☐ Voluntary Term Life Insurance: lifebenefits.com/statoftn

☐ UT Payroll Beneficiary: https://irisweb.tennessee.edu/irj/portal

☐ 401(k) Traditional or Roth and 457(b): RetireReadyTN.gov

Notes:

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

EMPLOYEE INSURANCE CHECKLIST — STATE PLAN

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

DO NOT submit this form to Benefits Administration. This form must be completed during an employee's initial enrollment period. Place a check mark beside each item discussed. After completing the form, place the original in the employee's insurance or personnel file and give the employee a copy.

EMPLOYEE INFORMATION

NAME	EDISON ID	AGENCY

ELIGIBILITY AND ENROLLMENT

- ❑ Explain the eligibility criteria for employees and dependents.
- ❑ Explain enrollment must be completed within 30 days of their eligibility date. If completing a paper form, it must be returned to the human resource office with the applicable dependent verification documents by _____ to allow ABC time to submit a Benefit eForm to BA within the 30-day requirement. Explain enrollment in voluntary term life insurance is through the vendor's website.
- ❑ Explain new hire coverage start date. Most coverages start on the first day of the month after your hire date AND completion of one calendar month of employment. Voluntary term life coverage requires completion of three calendar months of eligible employment. Partial months worked will not count toward the employment requirement. Subject to meeting ALL eligibility and enrollment requirements, your coverage start date will be _____ for voluntary term life. Your coverage start date for other insurance benefits will be _____.
- ❑ Explain if not enrolled when first eligible, the employee will only be allowed insurance coverage during the year by approval through a special enrollment provision. If a completed application is not returned by the 15th of the month prior to coverage beginning, the employee may have double deductions on the first paycheck from which health premiums are collected. Explain guaranteed issue for disability and voluntary term life insurance.
- ❑ Explain changes which can be made during the fall annual enrollment period, effective the following January 1.
  - Employees/dependents may request to enroll in, cancel or transfer between health options and carriers
  - Employees/dependents may request to enroll in, cancel or transfer between dental and vision options
  - Employees may request to apply for short term and/or long term disability
  - Employees/dependents may request to enroll in voluntary accidental death insurance and apply for voluntary term life
  - Employees may request to start a flexible spending account

INSURANCE PRODUCTS

Health Options — each allows a choice of carrier and network

- ❑ Premier Preferred Provider Organization
- ❑ Standard PPO
- ❑ Consumer-driven Health Plan with a health savings account

Life Options

- ❑ Basic Term Life and Accidental Death and Dismemberment
- ❑ Voluntary Term Life
- ❑ Voluntary Accidental Death and Dismemberment

Other

- ❑ Dental — Prepaid and Preferred Provider
- ❑ Vision — Basic and Expanded Plans
- ❑ Flexible Benefits
- ❑ Short Term Disability (State and Higher Education)
- ❑ Long Term Disability (State and Higher Education)

INFORMATION TO BE PROVIDED

- ❑ Provide enrollment instructions for UT employees.
- ❑ Provide university benefits resources, including HR (www.utc.edu/hr) and benefits (www.utc.edu/benefits) webpages. Provide contact information for UTC HR office and campus ABC.
- ❑ Explain that BA/ParTNers for Health will communicate to member using contact information provided, including email address.
- ❑ Provide the ParTNers for Health URL, tn.gov/partnersforhealth. Describe information located there, including vendor materials, publications and the customer service page (emphasize search feature for network providers) with contact information for BA and vendor partners.
- ❑ Explain where to find online forms for health, dental, disability, vision, life, retirement, leave of absence, flexible benefits enrollment and reimbursement and miscellaneous forms, provide printed copies if requested. Provide the url to the voluntary term life insurance website.
- ❑ Provide access to the eligibility and enrollment guide and HIPAA privacy notice or printed copies if requested.
- ❑ Explain the benefits available through the Employee Assistance Program and the wellness program.
- ❑ Explain flexible, medical, limited purpose, dependent care, transportation and parking reimbursement accounts.
- ❑ Explain the benefits available in the health, dental, disability, life and vision insurance programs.
- ❑ Explain monthly premiums, including employee deduction and employer contribution.
- ❑ Explain the deferred compensation choices and provide enrollment form or the web address to enroll.
- ❑ Provide the web address to the TennCare notice so employee is aware of responsibilities if they or their dependents are enrolled in TennCare.
- ❑ Explain the Summary of Benefits and Coverage and the marketplace letter and provide the web address or printed copies if requested.

EMPLOYEE SIGNATURE	AGENCY BENEFITS COORDINATOR SIGNATURE
DATE	DATE

RESET

KEYED: _____

VERIFIED: _____

PER# _____

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

2024 ENROLLMENT CHANGE APPLICATION

University of Tennessee Chattanooga • Office of Human Resources • Insurance Dept 3603
720 McCallie Ave • Chattanooga, TN 37403 • office 423.425.4452 • fax 423.425.4574

PARTNERS FOR HEALTH

PART 1: ACTION REQUESTED — PLEASE SEE PAGE 3 FOR INSTRUCTIONS

TYPE OF ACTION	COVERAGE	PARTICIPANTS AFFECTED	REASON FOR THIS ACTION	QUALIFYING EVENT - *review page 2, complete page 3 for medical/dental/vision*
☑ Add coverage	☐ Health	☐ Employee	☑ New Hire/Newly Eligible	☐ Marriage ☐ Death
☐ Change coverage	☐ Dental	☐ Spouse	☐ Court Order	☐ Newborn ☐ Divorce
Form not for cancellation	☐ Vision	☐ Child(ren)	☐ Annual Enrollment Revision	☐ Legal Guardianship ☐ Loss of Eligibility
	☐ Disability		☐ Other _____	☐ Adoption

PART 2: EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER	MARITAL STATUS
				☐ M ☐ F	☐ S ☐ M ☐ D ☐ W

SOCIAL SECURITY NUMBER	EMPLOYING AGENCY	EMPLOYER GROUP:	YOUR CURRENT STATUS
	University of Tennessee	☑ HED	☑ Active

HOME ADDRESS	☐ UPDATE MY ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: HEALTH COVERAGE SELECTION — CHOOSE CAREFULLY. EXCEPT FOR QUALIFYING EVENTS, CHANGES ARE NOT ALLOWED OUTSIDE THIS PLAN'S ANNUAL ENROLLMENT.

SELECT AN OPTION

☐ Premier PPO
☐ CDHP/HSA
☐ Standard PPO

HSA

Please complete an HSA deduction form requested from utinsurance@tennessee.edu

SELECT A CARRIER & NETWORK

☐ BCBS Network S
☐ BCBS Network P*
☐ Cigna LocalPlus
☐ Cigna Open Access*
*higher premium applies

SELECT A HEALTH PREMIUM LEVEL

☐ employee only
☐ employee + child(ren)
☐ employee + spouse
☐ employee + spouse + child(ren)

PART 4: DENTAL COVERAGE SELECTION

SELECT A PLAN

☐ Delta Dental DPPO
☐ Cigna DHMO (Prepaid Provider)

SELECT A DENTAL PREMIUM LEVEL

☐ employee only
☐ employee + child(ren)
☐ employee + spouse
☐ employee + spouse + child(ren)

PART 5: VISION COVERAGE SELECTION

SELECT A PLAN

☐ Basic Plan
☐ Expanded Plan

SELECT A VISION PREMIUM LEVEL

☐ employee only
☐ employee + child(ren)
☐ employee + spouse
☐ employee + spouse + child(ren)

PART 6: DISABILITY SELECTION (ST/UT/TBR)

SHORT TERM DISABILITY

☐ 60%/14 day Elimination Period
☐ 60%/30 day Elimination Period

LONG TERM DISABILITY

☑ Employer pays prem - 63%/90 day Elim Period
☐ Employee pay - 60%/90 day Elim Period
☐ Employee pay - 60%/180 day Elim Period
☐ Employee pay - 63%/180 day Elim Period

PART 7: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE *	SOCIAL SECURITY NUMBER	HEALTH	DENTAL	VISION
			☐ M ☐ F			☐	☐	☐
			☐ M ☐ F			☐	☐	☐
			☐ M ☐ F			☐	☐	☐

* 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 (see page 2).

☐ A separate sheet with more dependents is attached

PART 8: EMPLOYEE AUTHORIZATION

☐ Accept — I confirm that the information above is true. I understand my health, dental and vision selections are effective until the end of the plan year (December 31) subject to plan eligibility criteria, and that I cannot change insurance plans or carriers during the plan year. If I experience a qualifying event, I may be eligible for changes in enrollment of plan members and dependents (see pg 3). I understand that submission of fraudulent information may lead to consequences including cancellation of insurance, disciplinary action from my employer, or possible criminal penalties. I understand that if my dependent loses eligibility, it is my responsibility to notify my benefits coordinator, and coverage will terminate at the end of the month in which the loss of eligibility occurs. I understand that I will be held responsible for any claims paid in error if I fail to notify.

☐ Refuse — I have been given the opportunity by my employer to apply for the group insurance program and have decided not to take advantage of this offer. I understand that if I later wish to apply, I or my dependents will have to provide proof of a qualifying event or wait until annual enrollment.

EMPLOYEE SIGNATURE	DATE	HOME PHONE (REQUIRED)	EMAIL ADDRESS (REQUIRED)

AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR

ORIGINAL HIRE DATE	COVERAGE BEGIN DATE	POSITION NUMBER	EDISON ID	NOTES TO BENEFITS ADMINISTRATION

AGENCY BENEFITS COORDINATOR SIGNATURE	DATE	☐ PPACA Eligible ☐ 1450 Eligible

Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send to Benefits Administration.

DEPENDENT ELIGIBILITY

Definitions and Required Documents

PARTNERS FOR HEALTH

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	You will need to provide a document proving marital relationship **AND** one document from the additional documents list below:
		Proof of Marital Relationship • Government-issued marriage certificate or license • Naturalization papers indicating marital status
		Additional Documents • Bank Statement issued within the last six months with both names; **or** • Mortgage Statement issued within the last six months with both names; **or** • Residential Lease Agreement within the current terms with both names; **or** • Credit Card Statement issued within the last six months with both names; **or** • Property Tax Statement issued within the last 12 months with both names; **or** • The first page of most recent Federal Tax Return filed showing "married filing jointly" or "married filing separately" with the name of the spouse provided thereon; submit page 1 of the return with the income figures blacked out
		If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child's birth certificate (will accept mother's copy for newborn); **or**
		Certificate of Report of Birth (DS-1350); **or**
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); **or**
		Certification of Birth Abroad (FS-545)
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	Final court order granting adoption; **or**
		International adoption papers from country of adoption; **or**
		Court order placing child in custody of member for purpose of adoption
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse (as outlined above) **and** birth certificate of the child showing the relationship to the spouse, **or** documents determined by BA to be the legal equivalent
Disabled dependent	A dependent of any age who falls under one of the child categories previously listed and due to a mental or physical disability, is unable to earn a living. The dependent's disability must have begun before age 26 and while covered under a state-sponsored plan.	Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent's 26th birthday. Additional documentation will be required to comply with any future review. The insurance carrier will review the form, make a determination and provide BA with documentation once a determination has been made. If approved for incapacity, the child will continue the same coverage.
Child under age 26 placed for guardianship, custody or conservatorship with the head of contract* (placement order active or expired due to age of majority)	A child under age 26 for whom the head of contract is or has been the legal guardian, custodian or conservator	Valid order by a court of competent jurisdiction (placement order) establishing guardianship, custody or conservatorship arrangement between child and head of contract; **and** an attestation signed by the head of contract upon initial enrollment and upon request

*Head of contract is the person who elects coverage and has authority to change coverage elections.

Never send original documents. Please mark out or black out any Social Security numbers and any personal financial information on the copies of your documents BEFORE you return them.

RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

BASIC TERM LIFE/AD&D INSURANCE ENROLLMENT/CHANGE APPLICATION

University of Tennessee Chattanooga • Office of Human Resources • Insurance Dept 3603
720 McCallie Ave • Chattanooga, TN 37403 • office 423.425.4452 • fax 423.425.4574

PART 1: TYPE OF REQUEST

ENROLLMENT ❑ Add Coverage ❑ Change Coverage	❑ New Hire ❑ Newly Eligible	❑ Qualifying Event Change Request* Complete page 2 and page 3 (if applicable) and return to your agency benefits coordinator within the allowed timeframe.
BENEFICIARY DESIGNATION ❑ Add ❑ Change	Beneficiary Designation Effective Date: _____ Complete page 2 and return to your agency benefits coordinator.	

PART 2: ELECT COVERAGE

Employee only:

☑ I want full employee coverage paid by the state [Note: This is one times my base annual salary as of hire or Sept. 1 of each year (effective Jan. 1) with a minimum basic term life coverage of $50,000 and a maximum coverage of $250,000; coverage is reduced at ages 65, 70, and 75. Basic AD&D coverage is one times basic term life coverage. Imputed income, as explained in IRS Publication 15, for basic term life coverage above $50,000 will be shown on employee's W2.]

❑ I want only $50,000 of employee coverage paid by the state even though I qualify for coverage above $50,000 (Note: Coverage may be less than $50,000 if calculated coverage due to age is less than $50,000.)

PART 3: 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
	University of Tennessee		

HOME ADDRESS	CITY	ST	ZIP CODE

PART 4: EMPLOYEE AUTHORIZATION

I understand this enrollment is only for basic term life/basic AD&D coverage and that it is 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 (SGIP) to release information to its life insurance contractor on behalf of myself 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

PART 5: AGENCY SECTION – MUST BE COMPLETED BY AGENCY BENEFITS COORDINATOR

HIRE DATE	ABC SIGNATURE/DATE

NAME	EDISON ID	OR	SSN

PRIMARY BENEFICIARY DESIGNATION

	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
1.					
HOME ADDRESS			CITY	STATE	ZIP CODE
2.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
3.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
4.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
5.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
ADD PRIMARY BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.					**TOTAL BENEFIT %:**

CONTINGENT BENEFICIARY DESIGNATION (TO RECEIVE DEATH BENEFITS WHEN NO LIVING PRIMARY BENEFICIARY)

	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
1.					
HOME ADDRESS			CITY	STATE	ZIP CODE
2.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
3.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
4.	NAME	PHONE NUMBER	SSN	RELATIONSHIP	BENEFIT %
HOME ADDRESS			CITY	STATE	ZIP CODE
ADD CONTINGENT BENEFICIARY BENEFIT PERCENTAGES FROM THE LINES ABOVE. TOTAL MUST BE 100%.					**TOTAL BENEFIT %:**

As required by law, a Summary of Benefits and Coverage is available which describes your 2024 health coverage options. The SBC may be found at www.tn.gov/ ParTNersForHealth/summary-of-benefits-and-coverage no later than Sept. 1. The digital newsletter contains much of the same information. To get a SBC paper copy, free of charge, call 855.809.0071. Please include your name, complete mailing address and name of the SBCs you want: State and Higher Education Plan; Local Education Plan; or Local Government Plan.

The Plans are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to PHI. Find Notice of Privacy Practice and other important Legal Notices including Prescription Drug Coverage and Medicare and more at https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/legal_notices.pdf

Find the Notice Regarding Wellness Program at tn.gov/ParTNersForHealth under Wellness, or email benefits.info@tn.gov to request a mailed copy of the Wellness Program Notice.

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, contact the Finance and Administration Civil Rights Coordinator at FA.CivilRights@tn.gov or 615-532-9617.

Have you been denied services or treated differently for the above stated reasons? Find the Department of Finance and Administration's Nondiscrimination Policy and Complaint Procedures and Form under F&A Department Policies at https://www.tn.gov/finance/looking-for/policies.html (Policy 36); contact the F&A Civil Rights Coordinator; or mail a complaint to F&A Civil Rights Coordinator/Office of General Counsel, 20th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

Need free language help? Have a disability and need free help or an auxiliary aid or service such as braille or large print? If you speak a language other than English, help in your language is available for free. Contact the F&A Civil Rights Coordinator at 615-532-9617.

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-576-0029 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalan- gan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848- 0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለውቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

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

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

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　866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください。

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).

ध्यान दे: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करे।ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848- 0298).

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با این شماره تماس بگیری 866-576-0029 (TTY: 1-800-848-0298)

If you have questions about civil rights compliance or concerns, you may also contact:

- U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697.
- U.S. Office for Civil Rights, Office of Justice Programs, U.S. Department of Justice, 810 7th Street, NW, Washington, DC 20531.
- Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.