RESET

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) ❑ Other 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
	Univ of Tenn		

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

RDA 11367

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.

NAME	EDISON ID	OR	SSN

*__OTHER ENROLLMENT: You may have additional opportunities to enroll in Voluntary AD&D coverage if you or a dependent lose coverage under any other group plan, or if you acquire a new dependent during the plan year, subject to meeting all eligibility and enrollment criteria.__

**__DEPENDENT INFORMATION:__ The acquire date is the date of marriage, birth, adoption, guardianship, etc. __Proof of dependent's eligibility is required for all new dependents__ and must be submitted with your application. Ask your ABC about dependent verification documents or view information at https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/deva_eligible_docs.pdf.

INSTRUCTIONS: Check the box in the qualifying event section below to identify the event(s) which applies to you. Submit this page along with the required documentation, proof of prior coverage and your completed application.

NOTE: Application for enrollment must be made within 60 days of the loss of eligibility for other insurance coverage or within 30 days of a new dependent's acquire date. Voluntary actions resulting in loss of coverage (such as voluntary cancellation of coverage and cancellation for not paying premiums) ARE NOT qualifying events. Electing to cancel, waive or decline coverage during another plan's enrollment period IS NOT a qualifying event.

Retroactive coverage (a coverage effective date that begins before an enrollment is completed and submitted to BA) **is not allowed except for birth, adoption and placement for adoption**. For all other events, the earliest effective date allowed for coverage under this plan is the first day of the month following the date that your enrollment request, including all required documentation, is completed and submitted to BA. Enrollment should be completed and submitted to BA as soon as possible to ensure the earliest possible effective date. The examples provided below assume all eligibility requirements are satisfied and that required documentation is submitted with enrollment.

EXAMPLE 1	EXAMPLE 2
Marriage date is June 15 (30- day enrollment period applies): • enrollment submitted to BA on June 25 = 7/1 effective date • enrollment submitted to BA on July 10 = 8/1 effective date • enrollment submitted on or after July 16 will exceed the 30-day enrollment period, and your request will be denied	**Loss of other coverage date is June 30 (60-day enrollment period applies):** • enrollment submitted to BA on June 30 = 7/1 effective date • enrollment submitted to BA on July 10 = 8/1 effective date • enrollment submitted to BA on August 5 = 9/1 effective date • enrollment submitted on or after August 30 will exceed the 60-day enrollment period, and your request will be denied

QUALIFYING EVENT	EFFECTIVE DATE	DOCUMENTATION REQUIRED
❑ An event causing the loss of eligibility for coverage from another group AD&D insurance plan***	The effective date is the first day of the first calendar month after the date BA receives the request for special enrollment	Written documentation from an employer, former employer, insurance company, or former insurance company on company letterhead that lists (1) names of covered participants; (2) dates of coverage including your coverage at the time coverage in this plan was declined; (3) types of coverage (medical, dental, life, vision); (4) each participant that lost eligibility for coverage; (5) the date of loss of eligibility to continue coverage, and (6) the reason why eligibility for coverage was lost
❑ An event that results in acquisition of a new dependent spouse or stepchild acquired by marriage, or a child acquired pursuant to an order of guardianship****	The effective date is the first day of the first calendar month after the date BA receives the request for special enrollment	1. Marriage Certificate 2. Birth Certificate (will accept mother's copy for newborn) 3. Order of Guardianship requiring financial support and provision of insurance coverage, which sets out the date of the guardianship period
❑ An event that results in acquisition of a new dependent acquired by birth, adoption, or placement in legal custody for adoption****	The effective date is the date of birth, adoption, or placement for adoption	1. Birth Certificate (will accept mother's copy for newborn) 2. Final Order of Adoption or Order of Custody in anticipation of adoption

*** When eligibility for coverage under other insurance is lost, only the Employee and any dependents who lose the other coverage may enroll. The employee and dependents may only enroll in the types of coverage lost.

**** When a new dependent is acquired, an Employee may enroll in coverage for employee only or employee and dependent(s). The employee may add the new dependent and previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible).

2025

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 2025.

	Select your enrollment status	
	Individual HSA	**Family HSA**
A. Maximum amount that can be put in your HSA for 2025	$4,300	$8,550
B. Are you age 55 or older? **No**, write $0. **Yes,** write $1,000	+	+
C. How much your employer will contribute in 2025	- $ 500-	- $1,000-
D. A + B – C = *The **most** you can contribute in 2025*	=	=

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 2025.

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 2025 _____ (if paid biweekly max is 26)	E. Number of paychecks remaining in 2025 _____ (if paid biweekly max is 26)
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 — 2025 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 2025 is $3,200 (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 $3,200 (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 $640 remaining in either the Medical Expense Account or Limited Purpose Account at the end of the year will be forfeited. Funds of $640 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)