STATE OF TENNESSEE GROUP INSURANCE PROGRAM

INSURANCE CANCEL REQUEST APPLICATION

Knox County Schools - Benefits Department
P.O. Box 2188, Knoxville, TN 37901-2188 Fax (865) 594-9523

NAME	EDISON ID	EMPLOYER GROUP: ☐ HED ☐ STATE ☒ LOCAL ED ☐ LOCAL GOV

PART 1 — PARTICIPANT(S) CANCELING COVERAGE (ATTACH A SEPARATE SHEET IF NECESSARY)

I request to cancel ☐ medical coverage on the participant(s) below due to:

☐ Reason marked in Part 2 below

☐ Employee ☐ Spouse ☐ Child(ren) (names):

INSTRUCTIONS

You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment period except for one of the following events.

1. You and/or your dependent(s) may cancel coverage if you lose eligibility or qualify to cancel for one of the reasons listed below. Only persons who qualify may cancel. You have 60 days from a qualifying event to submit documentation.

The purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordinator.

PART 2 — REASON TO REQUEST TO CANCEL

REASON	DOCUMENTATION REQUIRED
☐ Marriage, divorce, legal separation, annulment	Copy of marriage certificate or divorce decree or legal paperwork signed by judge and proof of other coverage (see #1 above)
☐ Birth, adoption, placement for adoption	Copy of birth certificate or adoption documents and proof of other coverage (see #1 above)
☐ Death of spouse, dependent	Copy of death certificate
☐ New employment, return from unpaid leave, change from part-time to full-time employement (spouse or dependent)	Letter on employer's company letterhead certifying date of insurance eligibility, date of return from unpaid leave or change in employment status
☐ Entitlement to Medicare, Medicaid, TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card
☐ Court decree or order	Copy of court decree or order signed by judge
☐ Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage
☐ A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)	Letter stating date of location change with member's new address
☐ Marketplace Enrollment	I attest that I am enrolled or intend to enroll in the Marketplace

PART 3 — REQUESTED COVERAGE END DATE

The coverage end date may either be the last day of the month prior to the eligibility date of other coverage or the last day of the month that the event occurred.	LAST DAY COVERAGE TO BE ACTIVE (MM/DD/YY)

PART 4 — AUTHORIZATION

By signing this application, I attest that I and/or my dependent(s) are eligible to cancel coverage for the reason(s) marked in Part 1 of this form. I also attest that I can cancel disability coverage for any reason. I further attest that the information I am submitting is true and accurate. I understand that by making this request, the participant(s) whose coverage is cancelled will not be eligible for COBRA and that any future request for coverage will be subject to the Plan's eligibility and enrollment rules.

EMPLOYEE SIGNATURE	DATE	PHONE
AGENCY BENEFITS COORDINATOR SIGNATURE	DATE	NOTES