STATE OF TENNESSEE GROUP INSURANCE PROGRAM

# INSURANCE CANCEL REQUEST APPLICATION – ACTIVE

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 800.253.9981 • fax 615.741.8196

PARTNERS FOR HEALTH

| 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 ❑ dental ❑ short-term disability ❑ vision ❑ Voluntary AD&D for the following participants:

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

## INSTRUCTIONS — Submit page one and two of this form with required documentation to your agency benefits coordinator (ABC)

Coverage may only be canceled under a plan during the annual enrollment period except as provided in the Medical Plan Documents or applicable Certificates of Coverage available at www.tn.gov/partnersforhealth. You must mark the reason you are requesting to cancel coverage in Parts 2 or 3 below.

1. Health, dental, and/or vision coverage may only be canceled mid-year for the following reasons:
   a. Losing eligibility under a plan or becoming newly eligible for other coverage;
   b. Annual enrollment of spouse's employer plan with different coverage periods;
   c. Change in residence outside of national service area; or
   d. Change to the DHMO dental network that results in no participating general dentist within a 25- mile radius of the Head of Contract's home permits cancellation of DHMO Dental only (not applicable to Dental PPO, health, or vision).

Note: Purchase of a private policy, a provider or hospital leaving a network, and financial hardship do not qualify as reasons to cancel coverage under a plan.

2. Requests and documentation must be received within 60 days from the date of loss of eligibility or becoming newly eligible for other coverage, or within 60 days from the date of receipt of notice of new entitlement to Medicare or Medicaid.
3. If Head of Contract loses eligibility under a health, dental, or vision plan or becomes newly eligible for other similar plan coverage and requests to cancel coverage, the HOC and all dependents' coverage will be canceled. If a dependent loses eligibility under a health, dental, or vision plan or becomes newly eligible for other similar plan coverage only that dependent may cancel coverage.
4. Short-term disability and Voluntary AD&D require 30 days advance notice to be canceled, and they may be canceled during the year for any reason. Skip to Part 5 to cancel.

## PART 2 — INVOLUNTARY CANCELLATION — Coverage ends at the end of the month of the loss of eligibility

| REASON | DOCUMENTATION REQUIRED |
|---|---|
| ❑ Loss of Spouse eligibility due to divorce, legal separation, legal annulment<br>* Ex-Spouses are not eligible for coverage on the Plan | Final divorce decree, order of separation, or order of annulment signed by a judge. Must provide the ex-spouse's current address here: |
| ❑ Death of spouse or dependent | Copy of death certificate of deceased individual |

## PART 3 — VOLUNTARY CANCELLATION — Coverage ends the last day of the month this form is received by your ABC*

| | |
|---|---|
| ❑ New eligibility for group health insurance/benefits through spouse or dependent's employer | Complete No. 1 of the Attestation/Certification in Part 4 below |
| ❑ Annual enrollment of spouse, former spouse, or dependent's employer | Complete No. 2 of the Attestation/Certification in Part 4 below |
| ❑ Marketplace eligibility and enrollment<br>(Only Applicable to health insurance Benefits) | Complete No. 3 of the Attestation/Certification in Part 4 below |
| ❑ New entitlement to Medicare or Medicaid | Copy of new ID card or Letter of entitlement from Medicare or Medicaid |
| ❑ Termination of child support order of dependent child provided by National Medical Support Notice | Copy of Notice of termination of National Medical Support Notice |
| ❑ Change of residence out of the national service area | Date of location change with member's new address |
| ❑ Dental DHMO change to the network resulting in no participating general dentist within a 25-mile radius of the Head of Contract's home (only applicable to DHMO) | Must be confirmed by the dental insurance carrier and BA |

* All voluntary terminations are subject to review and approval by Benefits Administration *

## PART 4 ATTESTATION / CERTIFICATION

INSTRUCTIONS
If the reason for your cancellation request requires an attestation/certification, complete the section below that applies to your situation. All requests are subject to review and approval by Benefits Administration in accordance with the Medical Plan Document or applicable Certificate of Coverage and applicable law.

1. New eligibility for group health insurance/benefits through spouse or dependent's employer.

   I hereby certify that on the following date: _____, the individuals listed in Part 1 became newly eligible for coverage under a group benefit plan of the employer of the member's Spouse or Dependent because of either (select one):

   ❑ a change in marital status
   ❑ a change in employment status

   Coverage under the new health plan (select one):
   ❑ is already in effect
   ❑ will begin _____

2. Annual enrollment of spouse or dependent's employer.

   I hereby certify that on the following date: _____, the individuals listed in Part1 became eligible for coverage under a group benefit plan of the employer of the member's Spouse, former spouse, or Dependent because of the employer's annual enrollment.

   Coverage under the new health plan (select one):
   ❑ is already in effect
   ❑ will begin _____

3. Marketplace eligibility and enrollment.

   I hereby certify that on the following date: _____, the individuals listed in Part 1 became eligible for Marketplace health coverage.

   Coverage under the Marketplace health plan (select one):
   ❑ is already in effect
   ❑ will be in effect no later than the day immediately following the last day of my Tennessee State sponsored health insurance coverage

## PART 5 — AUTHORIZATION

By signing this Cancel Request Application, I attest and certify that I have read the instructions above and that the individuals listed in Part 1 of this form are eligible to cancel coverage for the reason(s) marked on this form. I certify that all of the statements on this form are true and accurate to the best of my knowledge and agree to provide appropriate documentation and paperwork to verify the change in status or other applicable event if requested. I understand that by making this request, the person(s) whose coverage is cancelled may 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 |
|---|---|---|
| | | |

By signing this form below, I certify that I received this form on the date stated below:

| AGENCY BENEFITS COORDINATOR SIGNATURE | DATE | NOTES |
|---|---|---|
| | | |

**Anti-discrimination and Civil Rights Compliance**

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, please call 615.532.9617.

If you think you have been denied services or treated differently for any of the above stated reasons, please find the TN Department of Finance and Administration's Non Discrimination and Complaint Policy at https://www.tn.gov/finance/looking-for/policies.html for guidance or contact the Department of Finance and Administration Civil Rights Coordinator at FA.CivilRights@tn.gov or 615.532.9617 for assistance.

You may request information regarding anti-discrimination or a Civil Rights Complaint form by mail to: State of Tennessee, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243 or by email to FA.CivilRights@tn.gov.

You may also request information regarding anti-discrimination from or submit a Complaint to:
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, Georgia 30303-8909 or 1.800.368.1019 or TTY/TDD at 1.800.537.7697; OR
U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531; OR
Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

**Need free language help?** If you speak a language other than English, help in your language is available for free. If you have a disability and need an auxiliary aid or service, for instance sign language, Braille, or large print, help is available for free. Please request language assistance by emailing renee.woodall@tn.gov and FA.CivilRights@tn.gov or calling 615.253.9926.

**Spanish**

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

**Arabic**

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

**Chinese**

注意：如果您會說中文，則提供免費的語言協助服務。 請致電 1-866-576-0029（電傳打字機：1-800-848-0298）。

**Vietnamese**

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

**Korean**

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

**French**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1800-848-0298).

**Laotian**

ຂໍ້ຄວນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີຢູ່. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

**Amharic**

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

**German**

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

**Gujarati**

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

**Japanese**

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

**Tagalog**

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).

**Hindi**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1800-848-0298) पर कॉल करें।

**Russian**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

**Persian**

**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-576-0029 (TTY: 1-800-848-0298) تماس بگیرید.