



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

**BASIC LIFE INSURANCE BENEFICIARY DESIGNATION APPLICATION**

State of Tennessee • Department of Finance and Administration • Benefits Administration  
26th Floor, 312 Rosa L. Parks Avenue • Nashville, Tennessee 37243 • 615.741.3590 or 1.800.253.9981

**TYPE OF REQUEST**

New Enrollment  
 Beneficiary Change

Enrolled in health coverage:  
 Yes     No

If yes, type of health coverage:  
 Employee only  
 Employee + dependents

This application is to be used to designate a beneficiary for basic life insurance coverages. Individuals who elect **NOT** to enroll in health insurance will be provided with basic term life and basic special accident coverage with the premium being provided by the State of Tennessee. These amount of coverage **CANNOT** be increased.

Individuals who **DO** elect health coverage will also receive the same state support; however, the amount of coverage will increase as your salary increases, with additional premiums deducted from your paycheck. If enrolling in health coverage, covered dependents will also receive life insurance benefits; however, the amount of coverage is different from that of an employee.

Please refer to the eligibility and enrollment guide for further information.

EMPLOYEE INFORMATION			
Name	Social Security Number	Edison ID (if known)	
Employing Department/Agency	Dept ID	Date of Hire	Date of Birth
Work Address	City	State	Zip Code
Home Address	City	State	Zip Code
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime Phone Number	

**AUTHORIZATION**

I understand that this enrollment is NOT for health insurance coverage and is for basic term life and basic special accident coverage only. Unless I enroll in family health insurance, coverage is provided to the employee only (not spouse or child). If I enroll in family health insurance coverage, my covered dependents will also be enrolled in basic life coverage; however dependents do not elect a beneficiary as the benefit will automatically default to me as the employee. I further understand that a new applicatoin 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 estate in the event of my death.

I authorize the state group insurance program to release to Dearborn National on behalf of myself and all family members information (name, address, social security number, age, gender, salary, enrollment effective/termination date) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The state group insurance program 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.

Upon termination of employment, I may continue this coverage on a direct pay basis to the insurance company; however, payment of monthly premiums is my responsibility.

I confirm that all information that I have provided on this application 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.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

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

Name	Edison ID	<b>OR</b>	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
<b>Total for Primary Beneficiary (must be 100%)</b>			<b>Total</b>

**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
<b>Total for Contingent Beneficiary (must be 100%)</b>			<b>Total</b>

NOTE: Contingent beneficiary will only receive benefits if all primary beneficiaries are deceased.