



**STATE GROUP INSURANCE PROGRAM  
OPTIONAL SPECIAL ACCIDENT ENROLLMENT APPLICATION**

State of Tennessee • Department of Finance and Administration • Benefits Administration  
26th Floor WRS TN Tower • 312 Rosa Parks Ave • Nashville, TN 37243 • 615.741.3590 • 1.800.253.9981 • Fax 615.741.8196

TYPE OF REQUEST	
<input type="checkbox"/> New Enrollment	
<input type="checkbox"/> Single	
<input type="checkbox"/> Family	
<input type="checkbox"/> Enrollment Change	

ACTION FOR ENROLLMENT CHANGE	
<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Terminate Coverage
<input type="checkbox"/> Terminate Dependent	<input type="checkbox"/> Change Beneficiary
<input type="checkbox"/> Update Dependent Eligibility	<input type="checkbox"/> Change Coverage Type to: <input type="checkbox"/> Single <input type="checkbox"/> Family
Effective Date of Change: _____	

EMPLOYEE INFORMATION			
Name		Social Security Number	EmplID (if known)
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Daytime Phone	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Employing Agency	Budget Code/Dept ID	Annual Salary	Date of Hire
Home Address		City	State      Zip Code

DEPENDENT INFORMATION						
Social Security Number	Name Last, First, MI	Birth Date mm/dd/yy	Relationship Code	Relationship as of date	Gender	Full-Time Student
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N

Relationship Codes:    SP – legally married spouse                      CS – stepchild                      CT – IRS tax dependent  
                                  CN – natural or adopted child                      CL – legal guardian

PRIMARY BENEFICIARY			
Name		Social Security Number	Relationship
Home Address		City	State      Zip Code

CONTINGENT BENEFICIARY			
Name		Social Security Number	Relationship
Home Address		City	State      Zip Code

AUTHORIZATION	
I confirm that all the above information 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