STATE OF TENNESSEE GROUP INSURANCE PROGRAM

REQUEST FOR RETROACTIVE TRANSACTION

State of Tennessee • Department of Finance and Administration • Benefits Administration
26th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590/1.800.253.9981 • Fax: 615.741.8196

Please type or print.

PART 1

Agency Name		Budget Code / Dept ID
Employee Name	**Social Security Number**	**Employee ID (if known)**

PART 2

Please indicate the reason(s) for the requested retro. Attach this form to a copy of the enrollment/change application and/or leave request form and send to Benefits Administration. You should retain a copy for your records. **Refunds will only be issued for three months. In instances of a retroactive cancellation of coverage, any claims paid will be deducted from the refund.**

Cancel Coverage	❑ Employee ❑ Dependent SSN ____________	Effective Date ____________ Plan Type/Benefit Plan ____________ Reason ____________
Reinstate Coverage	❑ Employee ❑ Dependent SSN ____________	Plan Type/Benefit Plan ____________ Reason ____________
Change Effective Date	❑ Employee ❑ Dependent SSN ____________	Effective Date ____________ Plan Type/Benefit Plan ____________ Reason ____________
Change Coverage Type	❑ Family ❑ Single ❑ Split ❑ Single Split	Effective Date ____________ Plan Type/Benefit Plan ____________ If Split coverage: Spouse Name ____________ Spouse SSN ____________ Spouse Empl ID (if known) ____________
Employee Should Have Been Placed on Leave of Absence	❑ Continue Coverage ❑ Suspend Coverage	Effective Date ____________ Date coverage to be termed ____________ (must be last day of the month)

PART 3

Agency Benefits Coordinator Signature	Date