Clear Form

KNOX COUNTY SCHOOLS
Benefits & Employee Relations Department
P.O. Box 2188, Knoxville, TN 37901-2188
Phone: 865.594.1686 / Fax: 865.594.3737

INSURANCE INTENT

This form must be completed by an employee to continue or suspend insurance coverage during an unpaid leave of absence. If an employee is using paid sick days, this form is not needed.

While on leave of absence, I wish to do the following with my insurance:

Health Insurance
- ☐ N/A - no current coverage
- ☐ Continue coverage during 12 week FMLA period only
- ☐ Continue coverage during entire leave
- ☐ Suspend coverage as soon as possible
- ☐ Suspend coverage as of _____

Dental Insurance
- ☐ N/A - no current coverage
- ☐ Continue coverage during 12 week FMLA period only
- ☐ Continue coverage during entire leave
- ☐ Suspend coverage as soon as possible
- ☐ Suspend coverage as of _____

Vision Insurance
- ☐ N/A - no current coverage
- ☐ Continue coverage during 12 week FMLA period only
- ☐ Continue coverage during entire leave
- ☐ Suspend coverage as soon as possible
- ☐ Suspend coverage as of _____

Life Insurance - Basic coverage which is paid by Knox County Schools as an active employee
- ☐ Continue basic coverage during 12 week FMLA period only
- ☐ Continue basic coverage during entire leave – *(additional paperwork required)*
- ☐ Suspend basic coverage as soon as possible
- ☐ Suspend basic coverage as of _____

Life Insurance - Supplemental coverage which is paid by the employee
- ☐ N/A - no current coverage
- ☐ Continue coverage during 12 week FMLA period only
- ☐ Continue coverage during entire leave
- ☐ Suspend coverage as soon as possible
- ☐ Suspend coverage as of _____

Life Insurance - Spouse coverage which is paid by the employee
- ☐ N/A - no current coverage
- ☐ Continue spouse coverage during 12 week FMLA period only
- ☐ Continue spouse coverage during entire leave
- ☐ Suspend spouse coverage as soon as possible
- ☐ Suspend spouse coverage as of _____

Life Insurance - Child coverage which is paid by the employee
- ☐ N/A - no current coverage
- ☐ Continue child coverage during 12 week FMLA period only
- ☐ Continue child coverage during entire leave
- ☐ Suspend child coverage as soon as possible
- ☐ Suspend child coverage as of _____

Maximum period for leave is two years.

Re-enrollment is not automatic. **Within 31 days of returning an employee must complete an enrollment form to re-enroll for coverage if it was suspended.** If coverage was terminated due to non-payment of premiums, the employee will not automatically be able to reinstate the coverage.

Coverage will be effective the first of the month after an employee returns from leave of absence.

_____	_____	_____
Date	Employee Name (print)	Signature
_____	_____	_____
EE#	Anticipated Beginning Date of Absence	School Year

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

LEAVE OF ABSENCE — CONTINUE COVERAGE

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

Agency Benefits Coordinator Use
SSN _____
EmplID _____

INSTRUCTIONS: This form is to be completed by a plan member to continue insurance benefits while on leave without pay. You must sign, date and return this form to your agency benefits coordinator.

FAILURE TO SIGN AND SUBMIT THIS FORM TIMELY WILL IMPACT YOUR BENEFITS.

LEAVE WITHOUT PAY — CONTINUE COVERAGE

- Maximum period to continue coverage is two years.
- Leave is approved by the employing agency.
- When you have been on leave without pay for one full calendar month, your agency benefits coordinator must notify Benefits Administration to transfer billing to your home address.
- You will be billed at home for 100 percent of the premium for health, dental, basic life and optional special accident coverages, if enrolled, once you no longer receive a paycheck.
- If applicable, you will be billed directly by the insurance carrier for optional term life, universal life and long-term care.
- If you do not return to active work status prior to the allowed two-year leave of absence, coverage will be discontinued and COBRA coverage will not be offered.
- You must return to work and be in a positive pay status for one full calendar month before you will be eligible to go on another leave of absence.
- If you become unable to continue paying the premiums you may request suspension of coverage. You must submit a written request, signed and dated, before your premiums are past due. If you request your coverage to be suspended during your remaining leave of absence you will be allowed to re-enroll upon your return to work.

TO BE COMPLETED BY EMPLOYEE

Employee Name (print)	Signature (required)	Date

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

Begin billing employee 100% for coverage effective (must be first of month)	End billing for coverage effective (must be first of month)	
Agency Benefits Coordinator Signature	Agency	Date

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

LEAVE OF ABSENCE — SUSPEND COVERAGE

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

Agency Benefits Coordinator Use
SSN _____
EmplID _____

INSTRUCTIONS: This form is to be completed by a plan member to suspend insurance benefits while on leave without pay. You must sign, date and return this form to your agency benefits coordinator.

FAILURE TO SIGN AND SUBMIT THIS FORM TIMELY WILL IMPACT YOUR BENEFITS.

LEAVE WITHOUT PAY — SUSPEND COVERAGE

- Maximum period for suspension is two years.
- All state group insurance program benefits are suspended, including any optional coverage.
- You must request to suspend coverage by completing this form prior to going on an approved leave.
- Premiums must be paid current and not be in a past-due status. You cannot request suspension if your premiums are past due.
- Re-enrollment is not automatic.
- Within 31 days after returning to active employment, you must complete an enrollment/change application to re-enroll (90 days if returning from military leave).
- If you fail to re-enroll timely, you will only be eligible by satisfying one of the special enrollment provisions or qualifying through medical underwriting.
- You may be subject to a six-month preexisting condition if returning to work after six months and do not provide a certificate of coverage for other health coverage.
- Coverage will be effective the first of the month after you return to work and your request for reinstatement has been received by Benefits Administration.
- Refer to the Insurance Handbook for further information on reinstating coverage.

TO BE COMPLETED BY EMPLOYEE

Employee Name (print)	Signature (required)	Date

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

Suspend Coverage Effective Date (must be first of month)

Agency Benefits Coordinator Signature	Agency	Date