|  |  |  |
| --- | --- | --- |
| **Retiree Name** *(As shown on TVA Records)* | **Social Security No.** | **Date of Birth** *(mm/md/yyyy)* |
|       |       |       |
| **Home Address** *(Street)* | **Apt. #** | **Home Phone No.** |
|       |       |       |
| **City** | **State** | **Zip Code** |
|       |       |       |

[ ] [ ]  Check here if this is a new address

|  |  |
| --- | --- |
| [ ] Spouse is/was a TVA employee. Provide name & Social Security No. |       |

Instructions

1. Completed form must be received by Employee Benefits **within 30 days of qualifying event.**
2. **If 30 days have passed, call Employee Benefits via TVA Connect at 1-888-275-8094 for more information.**
3. Complete Section A to identify family status change and date change occurred.
4. Check the desired coverage level and option *(if applicable)* in Section B and complete Sections C, D, E & F.
5. Changes must be consistent with family status change.

|  |
| --- |
|  |

Section A - Family Status Change– Identify dependent(s) affected by change on page 2 section D.

|  |
| --- |
| **Date of Family Status Change (Required)** |
|       |
|  |
| [ ] **Retiree gained a dependent by**: |
|  |
| [ ] [ ]  Marriage - Print Previous Name *(if applicable)* |       |  |
| [ ] [ ]  Birth | [ ] [ ]  Adoption *(legal documentation required)* | [ ] [ ]  Guardianship *(legal documentation required)* |
| [ ]  Dependent child lost health coverage due to termination or ineligibility in another plan |

[ ] **Retiree lost a dependent by:**

|  |  |  |
| --- | --- | --- |
| [ ] [ ]  Death [ ] [ ]  Divorce |  | [ ] [ ]  Spouse gained employment **(If spouse is removed from your insurance, you will not be able to add him/her back to insurance later.)** |
| [ ]  Dependent child gained health coverage due to employment or eligibility in another plan |

|  |  |
| --- | --- |
| Section B - Retiree Medical Plan |  |
| **Coverage Levels** | **Options (non-Medicare enrollee)** | **Via Benefits Medicare Supplement Plan\*** |
| [ ] [ ]  1. Individual[ ] [ ]  2. Family | [ ] [ ]  BCBS - 80% PPO[ ] [ ]  BCBS – Consumer Directed Health Plan[ ] [ ]  No Coverage | [ ] [ ]  Self[ ]  Spouse[ ] [ ]  Dependent**\*To enroll in a supplemental Medicare plan through Via Benefits, contact them at 844-620-5725. This form does NOT constitute enrollment.** |
|  |  |

Section C - Spouse Information

|  |  |  |
| --- | --- | --- |
| **Name** *(First, Middle, Last)* | **Social Security No.** | **Date of Birth** *(mm/dd/yyyy)* |
|       |       |       |

|  |
| --- |
|  |

Section D - Children Information - Identify dependent(s) affected by change in Section A

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name *(First, Middle, Last)*** | **Sex** | **Social Security****Number** | **Relation****Code\*** | **Birth Date*****(mm/dd/yyyy)*** |
|       |    |       |     |       |
|       |    |       |     |       |
|       |    |       |     |       |
|       |    |       |     |       |
|       |    |       |     |       |

\*Relation Codes:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NC** = natural child | **AC** = adopted child | **SC** = stepchild | **FC** = foster child | **LC** = legal custody/guardianship |

|  |
| --- |
| **Address If Different** *(Street, City, State, Zip)* |
|       |
|  |

Section E – Confirm Payment Options

[ ] [ ]  **PENSION PAYROLL DEDUCTION AUTHORIZATION.** By checking this block, you authorize TVA to deduct your medical plan contribution from your TVARS check. If your TVARS check is not sufficient, or if you are a member of CSRS or FERS, you may have your premium deducted from your bank account by completing a bank draft form.

[ ] [ ]  **BANK DRAFT DEDUCTION.** You may have your premiums automatically deducted from your bank account. If you choose this option, please complete TVA 17534, available electronically or from TVA Employee Benefits via TVA Connect at 1-888-275-8094 for more information.

|  |
| --- |
|  |

Section F - Checklist

1. **Did you complete all sections fully?**
2. **If other documentation is required, have you enclosed those copies?**

**I certify this information is accurate, and I authorize TVA to adjust my benefits and/or change my pension pay as a result of the changes elected.**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |       |  |
| ***Signature Required*** |  | ***Date Required*** |  |

**Return completed form to Employee Benefits:**

**Email –** **tvaemployeebenefits@tva.gov**

**Fax – 1-865-632-9682**

**Tennessee Valley Authority**

**Employee Benefits WT 8D-K**

**400 West Summit Hill Drive,**

**Knoxville, Tennessee 37902**