

<b>State of Tennessee</b>	<b>Court</b> _____ (Must Be Completed)	<b>County</b> _____ (Must Be Completed)
<b>Health Insurance Notice</b>		<b>File No.</b> _____ (Must Be Completed) <b>Division</b> _____ (Large Counties Only)
<b>Plaintiff</b> _____ (Name: First, Middle, Last) of Spouse Filing the Divorce)		
<b>Defendant</b> _____ (Name: First, Middle, Last of the Other Spouse)		

**You must:**

- Fill out this form completely, **OR** ask the person in charge of employee benefits where you work to fill it out.
- File the copy with the Court.
- Mail a copy to your spouse by certified mail. Keep a copy of this form for your records.

**Important!** Your spouse must receive this notice at least 30 days before the coverage ends.

**To** (Spouse's Name): \_\_\_\_\_

(Spouse's Address): \_\_\_\_\_  
Street address or P.O. Box City State Zip

**From** (Your Name): \_\_\_\_\_

(Your Address): \_\_\_\_\_  
Street Address or P.O. Box City State Zip

**If you do not have health insurance, check here.**  **Fill out the Certificate of Service section below, mail a copy of the form to your spouse, and file this form with the clerk's office.**

**If you do have health insurance, fill out the information about your health insurance policy that covers your spouse now:**

Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

(Employee Benefits Contact Person): (Name/Phone #/Street Address/City/State/Zip)

**Check one:**

- This policy has COBRA. That means the dependent spouse can keep the insurance after the divorce. BUT s/he must apply by the deadline and pay the premiums and any administrative charges. To learn more, speak to the employee benefits person listed above.
- This is a group insurance policy. The dependent spouse may be able to continue coverage under TCA § 56-7-2312(d)(1). To learn more, speak to the employee benefits person listed above. The dependent spouse may also get insurance from another source.
- This policy does not offer COBRA. That means the dependent spouse's coverage will end after the divorce. The dependent spouse must get other health insurance to be covered.
- My spouse is not covered by my policy.

**Certificate of Service:**

I hereby certify that a true and exact copy of this **Health Insurance Notice** was mailed to my insured spouse on  
(Date) \_\_\_\_\_ (MM/DD/YYYY) I sent it to the address listed above by certified mail.

Sign Here: ▶ \_\_\_\_\_ Date (MM/DD/YYYY) \_\_\_\_\_