State of Tennessee	Court _____ (Must Be Completed)	County _____ (Must Be Completed)
Health Insurance Notice		File No. _____ (Must Be Completed) Division _____ (Large Counties Only)

Plaintiff _____
(Name: First, Middle, Last) of Spouse Filing the Divorce)

Defendant _____
(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/DDD/YYY) _____