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) _____