

IN THE _____ CIRCUIT COURT FOR DAVIDSON COUNTY, TENNESSEE

Plaintiff [NAME (First, Middle, Last) OF SPOUSE FILING THE DIVORCE]

vs.

Docket No: _____

Defendant [NAME (First, Middle, Last) OF THE OTHER SPOUSE]

Health Insurance Notice

You must:

- Fill out this form completely **OR** ask the person in charge of employee benefits where you work to fill it out.
- File this completed *Notice* with the Court Clerk's Office.
- 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 and 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 that covers your spouse now, fill out the information about the health insurance policy that covers your spouse now:

Health Insurance Company Name: _____ Policy Number: _____

(Employee Benefits Person to Contact):

Name	Phone #	Street Address	City	State	Zip

Check one:

- This policy has COBRA. That means your 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. Your spouse may be able to continue coverage under *T.C.A. §56-7-2312(d)(1)*. To learn more, speak to the Employee Benefits Person listed above. Your spouse may also get insurance somewhere else.
- This policy does not offer COBRA. That means your spouse will lose this insurance after the divorce. Your spouse **must** get health insurance somewhere else.
- 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) _____ . I sent it to the address listed above by certified mail.

Sign here:  _____ Date: _____