

State of Tennessee	Court _____ (Must Be Completed)	County _____ (Must Be Completed)
Health Insurance Notice (Form 4)		File No. _____ (Must Be Completed) Division/Part _____ (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 insurance coverage ends. Most courts require you to send this to your spouse before you can get a hearing date.

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. Then fill out the **Certificate of Service** section below. Mail a copy of this paper to your spouse. File this paper with the court clerk's office.

If you **HAVE** health insurance that covers your spouse now, check here. Then fill out the information about your health insurance:

Health Insurance Company: _____ Policy Number: _____

(Employee Benefits Contact Person): (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 monthly premiums and any fees. To learn more, ask the employee benefits person listed above.
- This is a group insurance policy. The dependent Your spouse may might be able to continue coverage under TCA § 56-7-2312(d)(1). To learn more, ask 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) _____, (MM/DD/YYYY) I sent it to the address listed above by certified mail.

Sign Here: Date (MM/DD/YYYY) _____