State of Tennessee	Court CHANCERY (Must Be Completed)	County JOHNSON (Must Be Completed)
Health Insurance Notice (Form 4)		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 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. ☐ Fill out the Certificate of Service section below. Mail a copy of the paper to your spouse. File this form with the court clerk's office.

If you do HAVE health insurance that covers your spouse now, check here. ☐ Then 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 your spouse can keep the insurance after the divorce. BUT s/he must apply by the deadline and pay the premiums and any fees.To learn more, speak to the employee benefits person listed above.

☐ This is a group insurance policy. Your spouse might be able to continue coverage under TCA §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) _____. (MM/DD/YYYY) I sent it to the address listed above by certified mail.

Sign Here: _____ Date (MM/DDD/YYY) _____