



STATE GROUP INSURANCE PROGRAM

**DEPENDENT VERIFICATION FACSIMILE TRANSMITTAL SHEET**

State of Tennessee • Department of Finance and Administration • Benefits Administration  
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Please use this form when submitting dependent verification documents for employees who are sending documents via fax.

To: Benefits Administration

From: \_\_\_\_\_

Agency: \_\_\_\_\_

Employee ID: \_\_\_\_\_

Employee SSN: \_\_\_\_\_

Name of Employee: \_\_\_\_\_

Number of Documents: \_\_\_\_\_

Comments:

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