UNIVERSITY OF DELAWARE
HUMAN RESOURCES

ADDITIONAL INFORMATION FOR MEDICAL COVERAGE

Employee Name: _____

Name of Person Losing Coverage: _____

Relationship to Employee: _____

Name/Address of Former Employer: _____

_____

_____

Former Employer Phone: _____

Former Medical Carrier: _____

Medical Coverage End Date: _____

Upon completion of this form please upload at hrhelp@udel.edu or mail to the address below.

550 S. College Ave., Suite 201, Newark, DE 19713 · 302-831-2171