

## Domestic Partner Enrollment/Benefit Change Form

Please complete this form if you elect to enroll your domestic partner and/or eligible child(ren) of your domestic partner. Return the signed form to HR-Benefits. Please contact the Office of Human Resources by e-mail (ben-serv@udel.edu) or phone (302 831-2171) with any question about this form or your benefits. **Employee information** – Please help us keep your records current. Fill in your name, employee ID number and phone number. Include any other information that is applicable.

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

Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Department: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Status Change – Indicate the status change by marking an “X” in the appropriate box.

- |  |  |
|--|--|
| <input type="checkbox"/> Affirmation of Domestic Partnership | <input type="checkbox"/> Termination of Domestic Partnership |
| <input type="checkbox"/> Birth or Adoption of Child          | <input type="checkbox"/> Death of domestic partner/dependent |
| <input type="checkbox"/> Change in child’s eligibility       | <input type="checkbox"/> Other _____                         |

Explanation Required

Date of Change: \_\_\_\_\_

**Participant Information** – If you are removing a participant, please provide the individual’s current address:

	Street	City	State	Zip	
Circle Action (below)	Individual’s Name(s)	Gender	Social Security#	Birth Date	Relationship
Add/Remove					
Add/Remove					
Add/Remove					

**Please note** - documentation is required when initially enrolling an individual under the vision or dental plans. This includes an *Affidavit of Domestic Partnership* and birth or adoption certification when covering child(ren) of your domestic partner.

### Check the Benefits you are Electing/Changing:

	Pre-Tax Benefits		* After-Tax Benefits <input type="checkbox"/> Pre-Tax Benefits <input type="checkbox"/>		Dependent Life Insurance (After-Tax)
	Employee Only	Employee & Child(ren)	Domestic Partner	Domestic Partner & His/Her Child(ren)	
<b>Dental</b>					
Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$5,000 spouse/\$2,000 each child <input type="checkbox"/>
Waive	<input type="checkbox"/>				\$10,000 spouse/\$4,000 each child <input type="checkbox"/>
<b>Vision</b>					\$15,000 spouse/\$6,000 each child <input type="checkbox"/>
Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$20,000 spouse/\$8,000 each child <input type="checkbox"/>
Waive	<input type="checkbox"/>				Waive <input type="checkbox"/>

\* The deduction for vision coverage is after-tax, and the University contribution for dental coverage is taxable, unless same-sex domestic partner and his/her covered dependents meet IRS dependency guidelines.

### Changes during the year

Please know that you can change your pre-tax coverage between annual enrollments only if you have a change in status, as defined by federal law. A change in status happens when: a child joins your family through birth or adoption; your dependent child dies; your dependents become ineligible for coverage; you have a change in job status from full-time to part-time or vice versa; or you take an unpaid leave of absence. If you have a change in status, you have only 30 days to change your coverage. Furthermore, the requested change must be consistent with the event.

### Plan Authorization

I certify that all information supplied by me is true. I authorize the University to collect premium contributions by payroll deduction or otherwise, for remittance to applicable benefit carriers. I have read and agree with the above terms.

\_\_\_\_\_  
Signature

January 2008

\_\_\_\_\_  
Date