

## Same-Sex Domestic Partner Enrollment/Benefit Change Form

Please complete this form if you elect to enroll your same-sex 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 by marking an “X” in the appropriate box.**      **Date of Change:** \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Affirmation of Domestic Partnership<br><input type="checkbox"/> Birth or Adoption of Child<br><input type="checkbox"/> Change in child’s eligibility<br><input type="checkbox"/> Domestic Partner’s loss of/change in health coverage | <input type="checkbox"/> Termination of Domestic Partnership<br><input type="checkbox"/> Death of domestic partner/dependent<br><input type="checkbox"/> Other _____<br><div style="text-align: center; margin-left: 100px;">Explanation Required</div> |
|--|---|

**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						

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

### 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.

<b>Health Stipend</b>  Participate <input type="checkbox"/>  Not Eligible <input type="checkbox"/>	I certify that I have incurred expenses for which reimbursement is claimed and that:  <input type="checkbox"/> My partner’s employer does not provide health insurance coverage, or <input type="checkbox"/> My partner is not eligible for health insurance coverage, or <input type="checkbox"/> My same-sex domestic partner is not presently employed  <b>To receive this stipend, I understand that on a quarterly basis, I must submit to the Office of Human Resources a Reimbursement and Certification form, that includes supporting documentation of my health insurance payment. I must also notify the Office of Human Resources within thirty (30) days of any cancellation of coverage or availability of other coverage.</b>
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### 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 \_\_\_\_\_

Date \_\_\_\_\_