

# Family Status and Benefit Change Form

Please complete this benefits change form if you have experienced a change in family status (marriage/same-sex civil union, birth of a child, adoption, divorce, death of a spouse/partner or child, etc.); the benefits that you chose at the beginning of the plan year may be affected. Return the signed form to HR-Benefits **within 30 days** of the event. Please contact the Office of Human Resources - Benefits by e-mail (ben-serv@udel.edu) or phone (302 831-2171) with any question about this form or your benefits.

**Employee information** – Fill in your name, employee ID number and phone number, then identify any other information that has changed. Please print all information.

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

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

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Marriage/Civil Union          | <input type="checkbox"/> Divorce                       | <input type="checkbox"/> Death of spouse/partner or dependent |
| <input type="checkbox"/> Birth or Adoption of Child    | <input type="checkbox"/> Change in spouse’s/employment | <input type="checkbox"/> Change in your percent time worked   |
| <input type="checkbox"/> Change in child’s eligibility | <input type="checkbox"/> Moving out of service area    | <input type="checkbox"/> Other _____<br>Explanation Required  |

Date of Event: \_\_\_\_\_

**Dependent Information** – If you are removing a dependent, please provide the dependent’s current address:

Street		City			State	Zip
Action	Spouse/Partner/Dependent Name(s)	Gender	Social Security#	Birth Date	Relationship	Primary Care Physician (BlueCare and Aetna HMOs only)
						Current Patient?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

**Please note** - documentation is required when initially enrolling a dependent under a health plan. This includes a marriage/civil union certificate when covering a spouse/partner and birth or adoption certification when covering a dependent child(ren).

### CHECK ONLY THE BENEFITS YOU ARE CHANGING:

Medical	Employee Only	Employee & Spouse/Partner	Employee & Children	Family	Employee Life Insurance	
First State Basic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$10,000	<input type="checkbox"/>
Aetna CDH Gold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	<input type="checkbox"/>
BCBS CDH Gold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2X benefits base salary	<input type="checkbox"/>
Aetna HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	<input type="checkbox"/>
Blue Care HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4X benefits base salary	<input type="checkbox"/>
Comprehensive PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Waive	<input type="checkbox"/>					
<b>Dental</b>					<b>Dependent Life Insurance</b>	
Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$5,000 spouse/partner/\$2,000 child	<input type="checkbox"/>
Waive	<input type="checkbox"/>				\$10,000 spouse/partner/\$4,000 child	<input type="checkbox"/>
					\$15,000 spouse/partner/\$6,000 child	<input type="checkbox"/>
					\$20,000 spouse/partner/\$8,000 child	<input type="checkbox"/>
					Waive	<input type="checkbox"/>
<b>Vision</b>					<b>Long Term Disability</b>	
Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standard Option	<input type="checkbox"/>
Waive	<input type="checkbox"/>				High Option	<input type="checkbox"/>

**Flexible Spending Account – Healthcare**

- Total for the calendar year \_\_\_\_\_
- Waive

**Flexible Spending Account – Dependent (Day) Care**

- Total for the calendar year \_\_\_\_\_
- Waive

**Changes during the year**

Please know that you can change your coverage between annual enrollments only if you have a change in status, as defined by federal law. A change in status happens when: you marry, divorce or legally separate; a child joins your family through birth or adoption; your spouse becomes employed, loses his or her job (full-time employment) or involuntarily loses medical coverage; your spouse or dependent child dies; your dependents become ineligible for coverage; you or your spouse have a change in job status from full-time to part-time or vice versa; you or your spouse take an unpaid leave of absence; you or your spouse have a significant change in health coverage due to a change in your spouse's employment. 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.

**Spousal Coordination of Benefits Policy**

If you are covering your spouse/partner under a University health plan, we also want to share some very important information with you about the Spousal Coordination of Benefits Policy. This policy affects how health insurance benefits payments are made for spouses or partners who are eligible for, but not enrolled in, coverage through their employer. According to this policy, if your spouse/partner works full-time and would pay 50% or less of the total premium for individual coverage (premium based on the lowest-cost individual plan available through their employer), s/he must enroll in their employer's health plan. If your spouse/partner meets the above criteria, but does not enroll in his/her employer's health plan, the University's plan will pay only 20% of allowable charges. Misinterpretation and/or failure to comply with this policy may have significant financial implications for you. If applicable, please take a few minutes to read this policy and sign the spousal coordination of benefits policy form. Information on this form is shared with Statewide Benefits and is used to verify your spouse's or partner's access to health insurance. The Spousal Coordination of Benefits Policy Form can be found on our web site at: <https://secomb.delaware.gov/cob/>

**Health Plan Authorization**

I understand that rights to service are subject to acceptance of my enrollment and to the terms and conditions specified in the present contract between the health insurance carrier and the State of Delaware. I certify that all information supplied by me is true. I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents to the health insurance carrier or its designee for purposes reasonably related to their contract or as required by law.

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