Non-Active Family Status and Benefit Change Form

Please complete this benefits change form if you have experienced a change in family status (marriage, birth of a child, adoption, divorce, death of a spouse or child, etc.) as the benefits you chose at the beginning of the plan year may be affected. Return the signed form within 30 days of the event. Please contact us with any question about this form or your benefits.

Demographic information – Please help us keep your records current. Fill in your name, employee ID number, address, and phone number, then identify any other information that has changed.

Name:_____ Employee ID:_____

Home Address:_____ City/State/Zip:_____

Home Phone:_____ Date of Event:_____

Family Status Change – Indicate the family status change by marking an selecting in the appropriate change with an "X":

Marriage		Divorce		Death of spouse or dependent	
Birth or Adoption of child		Change in spouse's employment		Change in your percent time worked	
Change in child's eligibility		Moving out of service area			
Medicare eligible		Other, Explanation Required			

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

_____ Street _____ City _____ State _____ Zip

Action	Spouse/Dependent Name(s)	Gender	SSN	DOB	Relationship	Primary Care Physician (Aetna HMO, only)
Add						
Remove						
Add						
Remove						

Please note - documentation is required when initially enrolling a dependent under a health plan. This includes a marriage certificate when covering a spouse, and birth or adoption certification when covering a dependent child(ren) and a copy of their social security card.

CHECK ONLY THE BENEFITS YOU ARE CHANGING:

Medicare Supplemental Plan Selections	
Name:	**Please indicate your coverage election below with an "X":**
	Special Medicfill **with** prescription drug coverage **(must not be enrolled in a non-UD Medicare D plan)**
	Special Medicfill **without** prescription drug coverage (if enrolled in non-UD Medicare D prescription drug plan)
	Waive – Medical Coverage

Non-Medicare Plan Selections			
Name:_____ Please indicate your election below with an X:			
	Aetna CDH Gold		Highmark First State Basic
	Aetna HMO		Highmark Comprehensive PPO
	Waive		
Please indicate your coverage election below with an "X":			
	Individual		Individual & Child(ren)
	Individual & Spouse		Family

You must download this form to your computer to make fillable.

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Dental Plan Selections				Vision Plan Selections			
Please indicate your coverage election below with an "X":				**Please indicate your coverage election below an "X":**			
	Dominion Dental HMO				Enroll		
	Delta PPO Plus Premier		Waive		Waive		
Please indicate your level election below an "X":				**Please indicate your level election below an "X":**			
	Individual & Spouse		Individual & Child(ren)		Individual & Spouse		Individual & Child(ren)
	Individual		Family		Individual		Family

Changes during the year

Please know that you may be eligible to change your coverage between annual enrollments only if you have a change in status such as: 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; your spouse takes 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, or you become eligible for Medicare. 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 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 who are eligible for, but not enrolled in, coverage through their employer. According to this policy, if your spouse 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 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 access to health insurance. The Spousal Coordination of Benefits Policy Form can be found at: https://secomb.delaware.gov/cob/

Retiree Life Insurance

Retiree life insurance is administered by MetLife. Please contact MetLife Customer Service at 1-866-492-6983 with any questions or changes regarding billing, coverage, or beneficiary designations.

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 have read and agree with the above terms and authorize the University to collect premium contributions for remittance to applicable benefit carriers.

_____ _____

Signature (Participant) Date

_____ _____

Signature (Spouse of Participant) Date

If you have questions regarding this form or your benefits, please contact us by e-mail (hrhelp@udel.edu) or phone (302-831-2171). Please return your completed form to UD HR-Benefits Office, 413 Academy Street, Newark, DE 19716.

You must download this form to your computer to make fillable.

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