INDIANA UNIVERSITY

ANTHEM U65 PPO HDHP CHANGE FORM

2023 PLAN YEAR

HUMAN RESOURCES

Submit this form only if:

- you have an address change to report; or
- you wish to cancel your IU-sponsored medical coverage; or
- you wish to drop medical coverage for your dependents.

Complete only the sections that apply.

You can disregard this form if:

- your address remains the same; and
- you wish to continue enrollment in IU-sponsored medical coverage.

PARTICIPANT INFORMATION		
Last Name:	First Name:	Middle Initial:
Health Plan ID Number:		

ADDRESS CHANGE		
Complete this section only if you have an address change to report.		
Street:		
City:	State:	Zip:
Phone:	Email:	
Signature:		Date:

CANCEL COVERAGE

Complete this section only if you wish to cancel coverage for yourself and/or your dependent(s). Check all options that apply.

- ☐ Cancel my IU-sponsored medical plan coverage.
- ☐ Drop medical plan coverage for the following dependents:

Dependent Name	Relationship to You	Date of Birth (mm/dd/yyyy)

Signature:	Date:

To sign this form digitally you must first save it to your device.

Emailed to askhr@iu.edu; or mail to IU Human Resources, ATTN: Retiree Specialist, 420 N. Walnut St, Bloomington, IN, 47404.