INDIANA UNIVERSITY
HUMAN RESOURCES

GA/POSTDOCTORAL FELLOW/FELLOWSHIP RECIPIENT

DEPENDENT ENROLLMENT/FAMILY STATUS CHANGE

PERSONAL INFORMATION

Name: _____ **Social Security Number**: ___ ___ ___-___ ___-___ ___ ___ ___

University 10-Digit ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Gender:** ❑ Male ❑ Female **Date of Birth**: _____/_____/_____

Home Phone: (_____) _____ - _____ **E-mail:** _____

Home Address: _____ **City**: _____ **State**: _____ **Zip**: _____

REASON FOR ENROLLMENT

Complete this section to state reason for enrollment. If you have experienced a Family Status Change, explain the change in the space provided. Eligibility requirements will be verified before enrollment.

❑ **New Hire** ❑ **Family Status Change** **Explanation:** _____

❑ **Open Enrollment** _____

MEDICAL PLAN OPTIONS

Complete this section to make medical plan changes. Check all changes that apply. (Documentation required)

❑ **ADD** spouse to medical plan ❑ **DROP** spouse from medical plan ❑ **ADD** coverage due to loss of other insurance

❑ **ADD** child(ren) to medical plan ❑ **DROP** child(ren) from to medical plan

DENTAL PLAN OPTIONS

Complete this section to make dental plan changes. Check all changes that apply. (Documentation required)

❑ **ADD** spouse to dental plan ❑ **DROP** spouse from dental plan ❑ **ADD** coverage due to loss of other insurance

❑ **ADD** child(ren) to dental plan ❑ **DROP** child(ren) from to dental plan

DEPENDENT INFORMATION for MEDICAL and/or DENTAL COVERAGE

Complete this section by listing ALL covered dependents (spouse and/or children) that you wish to have enrolled in medical or dental coverage. **Attach all required documentation (e.g. marriage certificate or birth certificate) to this form.**

Name	Relationship*	Date of Birth* (mm/dd/yyyy)	Sex* M/F	SSN	Enroll in Medical?*	Enrol in Dental?*
					No	No
					No	No
					No	No
					No	No

*Required Information

If enrolling a spouse, enter date of marriage: _____/_____/_____

If you are dropping a spouse and/or child(ren) due to divorce, please indicate date of divorce: _____/_____/_____

AUTHORIZATION/CERTIFICATION

1. I request membership for myself and/or my dependent(s) in the plans I have elected on this form, for which I am also an eligible participant.
2. I have read and understand the university's plan eligibility requirements; the dependents listed on this form meet all eligibility requirements.
3. I understand it is my duty to notify the university within 30 days of any changes that affect the eligibility of any of my covered dependents; for example, marriage or divorce.
4. I understand that the plan may use my personal health information for the purposes of treatment, payment, health care operations, and other uses as outlined in the plan's privacy notice, and consistent with federal HIPAA regulations.
5. The information supplied on this form is true and complete. I understand that any intentional false information or statements will be grounds for IU to void my coverage.
6. I understand if required premium payments are not received in full by the deadline all dependents currently enrolled will be cancelled.

Participant Signature: _____ **Date**: _____/_____/_____

Mail Completed Form to IU Human Resources, ATTN: Student Healthcare, Poplars E165, 400 E 7th Street, Bloomington, IN, 47405
or **E-mail to *studenhc@iu.edu***

Clear Form Print Form

HR 2017

Eligibility

Eligible Graduate Appointees, Postdoctoral Fellows, and Fellowship Recipients may insure their dependents. This includes a spouse and children under the age of 26. Eligibility guidelines for each group are found online at:

- **Graduate Appointees and Postdoctoral Fellows**: *hr.iu.edu/benefits/GA-eligibility.html*
- **Fellowship Recipients**: *hr.iu.edu/benefits/fellowship-eligibility.htm*

Dependents may be covered from the date of eligibility of the enrollee and ceases when the enrollee is no longer a member of the eligible class for coverage.

To add dependents to the plan, IU Human Resources must receive the required supporting documentation (i.e. birth certificate, guardianship or adoption papers, marriage license, divorce decree, etc.) when submitting enrollment forms or changes.

Premiums and Payment

- Premiums for dependents of Postdoctoral Fellows in the School of Medicine are covered by the school.
- For all other dependents, ence the enrollment form is received and processed, billing and payment information will be mailed to the enrollee.
- Dependent premium rates are paid via check or money order on a monthly basis. Benefit payments are only accepted via submission to the mailing address provided on the billing statement. Credit cards and other payment methods are not accepted.
- Dependent coverage will not be activated until the first full premium payment is received by IU Human Resources.
- After the initial dependent enrollment and payment, payment is due the first of each month thereafter. Benefits coverage is subject to termination for payments not received by the date it is due.
- Premium information for each group is found online at:
  - → **Graduate Appointees and Postdoctoral Fellows**: *hr.iu.edu/benefits/GA-medical.html*
  - → **Fellowship Recipients**: *hr.iu.edu/benefits/fellowship-medical.html*

Questions

Contact IU Human Resources at *studenhc@iu.edu* or (812) 856-4650 for assistance.