INDIANA UNIVERSITY

DEPENDENT ENROLLMENT/LIFE EVENT CHANGE

GRADUATE APPOINTEES, POSTDOCTORAL FELLOWS, AND FELLOWSHIP RECIPIENTS

HUMAN RESOURCES

SECTION 1 PARTICIPANT INFORMATION

Name:		**Social Security Number:**	
University 10-digit ID:		**Date of Birth:**	
Home Phone:	**Email:**		
Home Address:	**City:**	**State:**	**Zip:**

SECTION 2 REASON FOR ENROLLMENT

State the reason for the enrollment below. If you experienced an IRS-qualifying Life Event (birth, marriage, loss of other coverage, etc.), explain the event in the space provided. Eligibility requirements will be verified before enrollment.

☐ **New Hire** ☐ **Open Enrollment** ☐ **Life Event** (explain):

SECTION 3 MEDICAL PLAN OPTIONS

Complete this section to make medical plan changes. Check all changes that apply.

☐ **Add spouse** to my plan ☐ **Drop spouse** from my plan ☐ **Add coverage** due to loss of other insurance

☐ **Add child(ren)** to my plan ☐ **Drop child(ren)** from my plan

SECTION 4 DENTAL PLAN OPTIONS

Complete this section to make dental plan changes. Check all changes that apply.

☐ **Add spouse** to my plan ☐ **Drop spouse** from my plan ☐ **Add coverage** due to loss of other insurance

☐ **Add child(ren)** to my plan ☐ **Drop child(ren)** from my plan

SECTION 5 DEPENDENT INFORMATION

List ALL of your covered dependents (spouse/children) below, indicating if they should be enrolled on your medical or dental plan, or both. Documentation to verify dependent eligibility (e.g. birth or marriage certificate) must be submitted with this form.

Full Legal Name	Relationship	Date of Birth (mm/dd/yyyy)	Sex (M or F)	SSN	Enroll in Medical?	Enroll in Dental?
					Select One	Select One
					Select One	Select One
					Select One	Select One
					Select One	Select One

If enrolling a spouse, enter date of marriage:

If dropping a spouse or dependent children due to divorce, enter date of divorce:

SECTION 6 PARTICIPANT CERTIFICATION

1. I request membership for myself and/or my dependent(s) in the plans I have elected on this form, for whick I am also an eligible participant.
2. I have read and understand the university's plan eligibility requirements. The dependents listed above meet all of these eligibility requirements.
3. I understand it is my responsibility to notify the university within 30 days of any changes that affect the eligibiity of any of my covered dependents.
4. I understand that the plan may use my personal health information for the purposes of treatment, payment, healthcare operations, and other uses as outlined in the plan's privacy notice, and consisten 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 groups for IU to void my coverage.
6. I understand if required premium payments are not received in full by the deadline, coverage for all of my covered dependents will be cancelled.

Signature:	**Date:**

To sign and submit this form digitally you must first save it to your device.
Return this form and any required documentation to studenhc@iu.edu or to IU Human Resources, 420 N. Walnut St, Bloomington, IN, 47404.

PRINT SAVE SUBMIT

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, once 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.