

HEALTH CARE COVERAGE CHANGE FORM



Employee Name		Empl ID#	
Address		City	State
		Zip Code	
Email Address		Work Phone	Home/Cell Phone

Please Indicate Type Of Change: <input type="checkbox"/> Addition of family member(s) <input type="checkbox"/> Deletion of family member(s) <input type="checkbox"/> Drop coverage for all – employee and dependent(s) <input type="checkbox"/> Student certification (you must complete the back of this form) <input type="checkbox"/> Request COBRA coverage	Please Indicate Date Of Status Change Event: _____ <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Foster Care/Legal Guardianship <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Obtained Other Coverage Other - Please explain: _____ <input type="checkbox"/> Dependent no longer eligible: <input type="checkbox"/> Marriage <input type="checkbox"/> No Longer Dependent on Employee for 50% of Support <input type="checkbox"/> Age 26 <input type="checkbox"/> No Longer Full-Time Student <input type="checkbox"/> No Longer Qualifies for Handicap Extension
---	--

Dependent Type	Check Option	Name (Include Last Name if Different from Employee)	Indicate Relationship	Birth Date Month/Day/Year	Address if Different from Employee
Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Husband		Address:
			<input type="checkbox"/> Wife		City: St: Zip:
Dependent Children (Includes: Adopted Children, Step Children, and Legal Guardianship Children)	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Daughter <input type="checkbox"/> Student		Address:
			<input type="checkbox"/> Son <input type="checkbox"/> Student		City: St: Zip:
	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Daughter <input type="checkbox"/> Student		Address:
			<input type="checkbox"/> Son <input type="checkbox"/> Student		City: St: Zip:
	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Daughter <input type="checkbox"/> Student		Address:
			<input type="checkbox"/> Son <input type="checkbox"/> Student		City: St: Zip:
	<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Daughter <input type="checkbox"/> Student		Address:
			<input type="checkbox"/> Son <input type="checkbox"/> Student		City: St: Zip:

Please return this completed form to:
 University of Utah Benefits Department ~ 420 Wakara Way, Suite 105, Salt Lake City, UT 84108
 Phone: (801) 581-7447 Fax: (801) 585-7375

I hereby request that the University of Utah Health Care Plan, hereinafter known as the Plan, change my membership in the Plan as noted hereon, subject to prevailing rules and regulations of the Plan. I certify that any information provided on this form is true and correct. I understand any family status change to my coverage must be made within three months of the event and may affect my monthly contribution rate. I understand that new coverage will be effective retroactive to the event date, unless I request that it be effective the day of this request. If this change results in an increase in my contribution rate, I acknowledge that any contributions due will be retroactively deducted from my pay. Failure to make the change within 3 months of the event will require that I wait until the next annual open enrollment to make the change. I understand that I must notify the Benefits Department within 60 days of the date my dependent becomes ineligible for coverage in order for the dependent to be eligible for COBRA Continuation Coverage.

Any person who knowingly files an enrollment form containing any misrepresentation or any false, incomplete, or misleading information may be subject to discipline up to and including termination of employment and cancellation of coverage, and may be guilty of a criminal act punishable under law and subject to civil penalties.

Employee Signature: _____ **Date:** _____

FOR BENEFITS DEPARTMENT USE ONLY

Coverage change from:	Coverage change to:	Effective date:	Date eligible for COBRA:	Date sent to COBRA:
-----------------------	---------------------	-----------------	--------------------------	---------------------

STATEMENT OF UNDERSTANDING AND AGREEMENT FOR STUDENT-DEPENDENT CERTIFICATION

Student-dependents listed on the reverse side of this form must meet ALL of the requirements listed below and provide a certified copy of student status from the institution your dependent is attending:

1. The student must continuously remain unmarried and the employee must continue providing at least 50% of the student's support.

2. The student must be enrolled on a full-time basis in an accredited university, college or vocational school; provided, however, that eligibility for coverage will continue during one semester if the student is enrolled full-time immediately in the prior semester and will be enrolled in the next semester. This information must be verified upon the dependent's **26th** birthday. Recertification will be requested annually by the claims administrator.

The student will cease to be eligible for coverage and benefits on his/her graduation date, the last day the student attends classes, or if a change of status occurs wherein the student fails to meet any of the above conditions. Under such circumstances, the student may be eligible for continuation of coverage through COBRA if the Benefits Department is notified of the change in status within **60 days**. Contact the University Benefits Department at (801) 581-7447 for details.

STUDENT'S FULL NAME:	BIRTH DATE:
NAME OF SCHOOL STUDENT IS ATTENDING: [] INCLUDE INSTITUTION CERTIFICATION	ANTICIPATED GRADUATION DATE:
SCHOOL ADDRESS: _____	CITY: _____ STATE: _____ ZIP: _____
EMPLOYEE SIGNATURE _____ DATE _____	

(USE IF MORE THAN ONE DEPENDENT IS BEING CERTIFIED)

STUDENT'S FULL NAME:	BIRTH DATE:
NAME OF SCHOOL STUDENT IS ATTENDING: [] INCLUDE INSTITUTION CERTIFICATION	ANTICIPATED GRADUATION DATE:
SCHOOL ADDRESS: _____	CITY: _____ STATE: _____ ZIP: _____
EMPLOYEE SIGNATURE _____ DATE _____	