

# Purdue University Voluntary Dental Plan

## Enrollment Change Form/ CIFS

Underwritten by Delta Dental Plan of Indiana. Administered by **USI Affinity**, 1 (866) 787-3838.

### Select Your Coverage: (Please check one.)

Delta Dental PPO Point of Service Plan (allows use of any dentist)  
Delta Dental PPO Standard Plan (usually requires use of a dentist that's a member of Delta's PPO, not Premier, Network)  
Terminate Coverage

### Who Will Be Covered: (Please check one, and then enter dependent information on the form.)

Enrollee only  
Enrollee and children  
Enrollee and spouse or same-sex domestic partner (SSDP)  
Enrollee and family

### Enrollee Information: (Please print)

Name \_\_\_\_\_  
(Last, first, middle initial)

Purdue Identification No. **(required)** \_\_\_\_\_ Birth Date \_\_\_\_\_ Male Female  
(mm/dd/yyyy)

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_  
(optional)

### Enrollment Status: (Please check one.)

New hire. Hire date: \_\_\_\_\_ (Coverage will be effective the first day of the following month.)

Already employed, but recently appointed to a position eligible for dental. Appointment date: \_\_\_\_\_

Change in family status (CIFS). Status change date: \_\_\_\_\_ **(Complete section below.)**

### Reason For The Change In Benefits (Must relate to the benefit changes requested.)

Marriage  
Beginning/End of Same Sex Domestic Partner Relationship  
Birth of a Child  
Death of Spouse/Child  
Legal Adoption/Placement in Employee's Home  
Arrival or departure of Family Members to/from the U.S.A.  
Divorce/Legal Separation/Annulment  
Reduction in hours of Employment (FTE)  
Beginning/End of unpaid leave  
Involuntary Loss of Outside Coverage  
Judgment/Decree/Court Order for coverage of children  
Dependent No Longer Eligible; please provide reason: \_\_\_\_\_

### Employment Status: (Please check one.)

Regular faculty or staff position  
Graduate student employee with at least a 50% FTE position  
Official retiree  
Disabled and approved for long term disability benefits  
COBRA participant  
Employed with Purdue Research Foundation or Purdue Alumni Office  
Fellowship recipient or a combination fellowship/grad student employee appointment  
Other Please explain: \_\_\_\_\_

### Dependent Information: (If you have more than four dependents, please attach an additional sheet.)

Spouse/ SSDP's Name \_\_\_\_\_  
(Last, first, middle initial)

Birth Date \_\_\_\_\_ Male Female

Dependent #1's Name \_\_\_\_\_  
(Last, first, middle initial)

Birth Date \_\_\_\_\_ Male Female

**(Over, Please)**

Dependent #2's Name \_\_\_\_\_  
(Last, first, middle initial)

Birth Date \_\_\_\_\_ Male Female

Dependent #3's Name \_\_\_\_\_  
(Last, first, middle initial)

Birth Date \_\_\_\_\_ Male Female

Dependent #4's Name \_\_\_\_\_  
(Last, first, middle initial)

Birth Date \_\_\_\_\_ Male Female

I authorize the selections I have made as well as the payment required for those selections. I understand that these selections are effective as of the 1<sup>st</sup> day of the month following the status change. I certify that the dependent coverage information is accurate.

**IMPORTANT:** The request for change in coverage must be submitted to the Administrators Office and Staff Benefits within 31 days of the change in family status event. Otherwise, you will forfeit rights to continue coverage through COBRA, if applicable, and you wait until open enrollment to make the change in coverage. **Please submit a copy of this form to: HRS, Staff Benefits, Freehafer Hall, immediately.**

**Enrollee's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Important Information:**

Please submit your completed enrollment form and a Payroll Deduction Authorization form to:

**Purdue Voluntary Benefits Program  
USI Affinity/ Plan Administrator  
P.O. Box 505  
Matawan, NJ 07747**

**(Do not send your enrollment form to Purdue University Staff Benefits.)**

If you have questions about dental plan coverage or the status of a dental claim, please contact Delta Dental Plan of Indiana at 1 (800) 524-0149.

Our Web site provides several additional items of information that will assist you with your dental plan – both while enrolling and after your coverage is in effect. Some of the items available include:

- Dental plan summaries
- Frequently asked questions about the dental plan
- Lists of dentists currently participating in Delta's provider network
- Guidelines on determining the usual and customary fees that Delta will cover
- Payroll Deduction Authorization Form
- Bank Draft Authorization Form (for retired, disabled, or COBRA faculty and staff and for fellows)

To access this information, visit [www.purdue.edu/hr/dental.htm](http://www.purdue.edu/hr/dental.htm).