

PURDUE UNIVERSITY
Change in Family Status Certification Form

This affects core benefits only and does not affect voluntary benefits such as dental.

Section 1. ABOUT YOU

A. Employee Name: _____ **C. Campus Phone Number:** _____
B. PUID Number: _____

Section 2. REASON FOR THE CHANGE IN BENEFITS (must relate to the benefit changes requested)

Reason for the Change	Date	Reason for the Change	Date
<input type="checkbox"/> Marriage	_____	<input type="checkbox"/> Reduction in Hours of Employment (CUL)	_____
<input type="checkbox"/> Beginning/End of Same-Sex Domestic Partner Relationship	_____	<input type="checkbox"/> Judgment/Decree/Court Order for Coverage of Children	_____
<input type="checkbox"/> Birth of a Child	_____	<input type="checkbox"/> Involuntary Loss of Outside Coverage	_____
<input type="checkbox"/> Legal Adoption/Placement in Employee's Home (provide copy of court documents)	_____	<input type="checkbox"/> Significant Change in Cost/Coverage *Does not apply to Health Care FSA	_____
<input type="checkbox"/> Arrival or departure of Family Members to/from the U.S.A.	_____	<input type="checkbox"/> Beginning/End of Unpaid Leave	_____
<input type="checkbox"/> Dependent Becomes Eligible for Coverage	_____	<input type="checkbox"/> Open Enrollment at Spouse's Employer	_____
<input type="checkbox"/> Death of Spouse/Child	_____	<input type="checkbox"/> Loss of Spouse's Employment & Benefits	_____
<input type="checkbox"/> Divorce/Annulment (provide copy of court documents)	_____	<input type="checkbox"/> Eligible/Ineligible for Medicare/Medicaid	_____
<input type="checkbox"/> Dependent No Longer Eligible; please provide reason: _____	_____	<input type="checkbox"/> Begin Spouse's Employment/Benefits at (Check One): Purdue <input type="checkbox"/> Elsewhere <input type="checkbox"/>	_____

Section 3. MAKE CHANGES TO THESE BENEFIT PLANS

A. Medical: Mark one or more of the actions below to adjust your medical coverage.

1. Add coverage for me. Please indicate the plan AND level of coverage desired.

PLAN	COVERAGE LEVEL
<input type="checkbox"/> Purdue Choice Fund	<input type="checkbox"/> You Alone
<input type="checkbox"/> Purdue Incentive	<input type="checkbox"/> You & Children
<input type="checkbox"/> Purdue Copay	<input type="checkbox"/> You & Spouse
	<input type="checkbox"/> You & Family

2. **Add Dependents***: H = husband, W = wife, P = same-sex domestic partner, S = son, D = daughter

When you add a dependent to your coverage, you must provide verification that the person you are adding is an eligible dependent. Please refer to the [Dependent Eligibility](#) information.

	Name	Social Security # (Required by law)	Relationship					Birth Date
			H	W	P	S	D	
Dependent 1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dependent 2	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dependent 3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dependent 4	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

3. Discontinue enrollment for my dependents and me (if applicable)

4. Continue my enrollment, but drop the following dependents*

	Name	Address, if different from yours
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____

*More dependents than space? List additional dependents and information about them on a separate sheet.

