

Graduate Staff Insurance Change Form Purdue University – West Lafayette Campus

Graduate Student's Name: _____

Graduate Student's Address: _____

Graduate Student's PUID: _____ Date of Birth: _____

Email Address: _____ Phone: _____

Section 1 –Coverage Change (To change address only, use Section 2)

You are eligible to change your coverage only when you experience one of the qualifying events listed below. The coverage change must directly relate to the qualifying event and must be requested within 31 days after the event occurs. Please indicate the applicable event below by filling in the date of the event.

<u>EVENT:</u>	<u>DATE:</u>
Marriage	__/__/__
Divorce/Legal Separation	__/__/__
Death of Spouse/Child	__/__/__
Birth of Child	__/__/__
Legal Adoption/Placement in Employee's Home	__/__/__
Commencement of Spouse's Employment (Where? Please circle one: Purdue or Elsewhere)	__/__/__
Dependent Full-Time Student	__/__/__
Arrival or departure of Family Members to/from the U.S.A.	__/__/__
Dependent Not Eligible ¹	__/__/__
Involuntary Loss of Outside Coverage ²	__/__/__
Loss of Spouse's Employment & Benefits ²	__/__/__
Open Enrollment at Spouse's Employer ²	__/__/__

¹Reason no longer eligible: _____

²Name, address, and telephone number of the organizational representative is required for verification of previous coverage:

COVERAGE CHANGES REQUESTED:

- CONTINUE** Purdue Coverage, But Add/Drop Dependents(s) (Complete information in the ADD/DROP box below.)
- BEGIN** Purdue Coverage (Check this box only if you are not currently covered by this plan. If you wish to cover dependents, list them in the "ADD" category below.)
- STOP** Purdue Coverage

*Relationship: H = husband, W = wife, P = same-sex domestic partner, S = son, D = daughter

	<u>Name</u>	<u>Social Security #</u>	<u>Relationship</u>	<u>Birthdate(s)</u>
<u>ADD:</u>			H W P S D	
			H W P S D	
			H W P S D	
			H W P S D	
<u>DROP:</u>	<u>Name</u>	<u>Address (if different than yours)</u>		

Section 2 –Dependent’s Address Change (To change coverage, use Section 1 on page 1)

Dependent’s Name: _____

New Address: _____

NOTE: Use this form to change your dependent’s address. To change your own address, complete a University Form 13 and return it to you business office. Your completion of the Form 13 will ensure that all your University records are updated, not just your insurance record.

Section 3 –Your Certification and Approval (Please sign below to authorize changes you indicated in Sections 1 and 2)

I authorize the selections I have made as well as the payment required for those selections. I understand that these selections are effective from the date of the qualifying event and may not be changed unless I experience another qualifying event.

I also certify that the dependent coverage information provided on this form is accurate.

Signature: _____ **Date:** _____

Return form to Staff Benefits, Freehafer Hall