

MEDICAL/DENTAL CHANGE FORM FOR ADDING DEPENDENT(S)

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) - PRINT		STREET ADDRESS:		
DATE OF BIRTH	GENDER	CITY	STATE	ZIP CODE
EMPLOYEE #		MARITAL STATUS	If Married/Domestic Partnership/Civil Union, Is Spouse or Partner a State of CT employee?	

CURRENT INSURANCE COMPANY (CIRCLE ALL THAT APPLY):	
MEDICAL Anthem Oxford Health HealthNet	DENTAL Aetna DMO United Dental Basic United Dental Enhanced PPO Cigna Dental PPO <i>(Graduate Assistants Only)</i>

TYPE OF INSURANCE YOU ARE PLANNING TO ADD YOUR DEPENDENT(S) TO (Circle ONE):

MEDICAL	DENTAL	BOTH MEDICAL AND DENTAL
---------	--------	-------------------------

ABOVE-MENTIONED ADDITION WILL INCLUDE (Circle all that apply):

SPOUSE/DOMESTIC PARTNER/CIVIL UNION	DEPENDENT CHILD/CHILDREN
-------------------------------------	--------------------------

REASON FOR ADDITION (Circle ONE choice and provide date the event took place):
Note: This form MUST be returned within 30 days of event date with all required documents
If dependent is enrolled in Medicare, please attach copy of Medicare card.

Marriage Date of Marriage: _____ Attach Marriage Certificate Domestic Partnership Event Date: _____ Attach Affidavit Civil Union Date of Civil Union: _____ Attach Civil Union Certificate Birth Date of Birth: _____ Attach Birth Certificate Adoption Date of Adoption: _____ Attach Adoption Decree	19 -23 Year Old Dependent is now a full time student (Medical Insurance Only) *Attach proof and other supporting dependent documentation Date of Semester Start: _____ Loss of other coverage Date of Loss: _____ Attach written notification of loss from prior insurance company and other supporting dependent documentation. Family Entering U.S. Family's Date of Entry: _____ Attach Entry Documentation and other supporting dependent documentation
--	--

COMPLETE FOR ALL PERSONS TO BE ADDED TO CURRENT PLAN:

NAME OF DEPENDENT (Please include Last Name, if different)	BIRTH DATE	SOCIAL SECURITY #	ADDRESS (if different from above)	RELATIONSHIP TO EMPLOYEE

*PLEASE NOTE: If you are adding a dependent child that is between the ages of 19 and 23, attach proof that the dependent child is enrolled as a full time student for the current semester and please send proof for each subsequent semester that the child is a full time student. Dependent children over the age of 19 are not eligible for dental, regardless of their student status.

I certify that above information is correct. I authorize the above-mentioned changes and any changes made to my payroll deductions that result from this/these change(s):
Signature: _____ **Date:** _____

SEND SIGNED FORM TO: UConn Human Resources, 9 Walters Avenue Unit 5075, Storrs, CT 06269-5075

FOR OFFICE USE ONLY:
DATE: _____ **INITIALS:** _____

Documentation Requirements for Enrollment of Dependents for Health Benefits

The following documentation must be submitted with the enrollment form for health insurance benefits at the time of application for coverage:

- If an eligible dependent is being added after initial enrollment but outside of the open enrollment period due to loss of other health insurance coverage, you must submit the required documentation and official notification of the loss of coverage (COBRA notification or notice from employer of loss of benefits).
- If an eligible dependent is being added due to a life event, the required documentation must be submitted.
- **All required documentation must be received by Human Resources within 30 days of the event date.**

RELATIONSHIP	DOCUMENTATION REQUIRED
Medicare Enrolled Employee or Dependent	Copy of Medicare Card
Spouse	MARRIAGE CERTIFICATE
Party to a Civil Union	Civil Union Certificate
Dependent Child Under Age 19 <ul style="list-style-type: none"> - Employee is birth parent - Employee is Legal Guardian - Employee is adoptive parent - Employee is Step Parent 	<ul style="list-style-type: none"> - Birth Certificate - Documentation of Legal Guardianship - Adoption Decree or Birth Certificate - Tax forms indicating child is claimed as a dependent of employee and employee's spouse or partner, living with the employee
Dependent Child Over Age 19 <ul style="list-style-type: none"> - Full time Student (19-23) - Disabled Child (over 19) 	Requires documentation noted above (if not already submitted) plus: <ul style="list-style-type: none"> - Certification from educational institution verifying status as a full time student - Completion of medical verification form
Same Sex Domestic Partner	If enrolling a same sex domestic partner, you must complete the Domestic Partnership Affidavit CO-1049, have the form notarized, and attach the supporting documentation as outlined in the affidavit. Link to affidavit:: http://www.osc.state.ct.us/agencies/forms/othforms/word/DomesticPartnershipAffidavit.doc Or contact the Benefits Unit to request a copy: 860-486-0411 or benefits@uconn.edu