



UNION CODE _____

HEALTH INSURANCE ENROLLMENT / STATUS CHANGE FORM

New Hire Open Enrollment Qualified Status Change Address Change

Effective Date: ___ / ___ / ___ Payroll Account No: _____

1. EMPLOYEE INFORMATION: Please Print

NAME:			SSN:	HIRE DATE:
First	MI	Last		
ADDRESS:			PHONE: ()	
Street	City	State	Zip	
MARITAL: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Common Law	DOB:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F	

2. QUALIFIED STATUS CHANGE: Supporting documentation must be submitted for all status changes listed in this section within 31 calendar days (except for Marriage which is 60 calendar days).

Marriage Divorce Death Birth/Adoption Loss of Coverage

Change from full-time to part-time employment or vice versa for you or spouse Spouse's Employment Begins or Ends or Open Enrollment Compliance with certain Family Relations Order or Decrees

3. MEDICAL COVERAGE INFORMATION – UNITEDHEALTHCARE (UHC)

Enroll Change Waive (Medical Waiver Form must be attached) Individual Plan Family Plan (Must complete Section 6 Dependent Info)

4. DENTAL COVERAGE INFORMATION - DELTA DENTAL OF RHODE ISLAND (DD)

Enroll Change Waive Individual Plan Family Plan (Must complete Section 6 Dependent Info)

5. VISION COVERAGE INFORMATION – VISION SERVICE PLAN (VSP)

Enroll Change Waive Individual Plan Family Plan (Must complete Section 6 Dependent Info)

6. DEPENDENT INFORMATION: Attach separate sheet for additional dependents.

Check One		Name (First, MI, Last)	Relationship*	Dependent SSN	Sex M/F	Birth Date MM/DD/YY	Student (19-25)***
Enroll	Drop						
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>

Relationship: S=Spouse C=Child CL=Common Law** DP=Domestic Partner*
 Affidavit of Domestic Partnership with Dependent Declaration Form or Affidavit of Common Law Marriage required. *Affidavit of Student Status required.

7. DUAL COVERAGE:

Does your spouse work for the state? Y N If yes, does he/she have family coverage? yes (Fill out information below) no

Spouse's Name: _____ Spouse's SSN: _____

8. EMPLOYEE APPROVAL AND AUTHORIZATION:

If any employee contributions are required for coverage, I authorize the deductions of these amounts from my wages. In addition, I certify that the above information is true and correct to the best of my knowledge and understand that, by law, I can only change my election(s) during Open Enrollment or when I have a qualified status change as defined by section 125 IRS status change rules and I submit the required documentation within 31 days of the change (except for marriage, which is 60 days.)

Employee Signature: _____ Date: _____

OFFICE USE ONLY Processed by Benefits Office:	Processed by Payroll Office:
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