



ENROLLMENT FORM FOR GRADUATE STUDENT EMPLOYEES/FELLOWS AND THEIR DEPENDENTS

NEW RE-APPOINTED ADD DEPENDENT DELETE DEPENDENT TERMINATE ADDRESS CHANGE CARD REQUEST

LAST NAME:	FIRST NAME:	SOCIAL SECURITY #
		SCHOOL ID #

MAILING ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

DATE OF BIRTH ____/____/____	SEX CODE M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL CODE SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> → MARRIAGE DATE ____/____/____
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HOME PHONE #	WORK PHONE#	CELL PHONE#	Have you been enrolled in the TA/GA health insurance plan within the last 28 days? If yes check box <input type="checkbox"/>
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DEPARTMENT NAME & ZIP	EMAIL ADDRESS:	VISA TYPE : F1 <input type="checkbox"/> J1 <input type="checkbox"/>
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ENTER REQUEST BELOW (CHECK ONE BOX)

I DECLINE COVERAGE INDIVIDUAL INDIVIDUAL +1 INDIVIDUAL +2 OR MORE

REASON FOR CHANGE

<input type="checkbox"/> CHANGE TO FAMILY <input type="checkbox"/> CHANGE TO INDIVIDUAL <input type="checkbox"/> ARRIVAL OF ELIGIBLE DEPENDENT IN UNITED STATES <input type="checkbox"/> REQUEST COVERAGE FOR DEPENDENTS <input type="checkbox"/> REQUEST FOR DOMESTIC PARTNER HEALTH INSURANCE	<input type="checkbox"/> MARRIAGE _____ <input type="checkbox"/> NEW BORN _____ <input type="checkbox"/> SPOUSE COVERAGE ENDED _____ <input type="checkbox"/> OTHER _____
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DEPENDENT INFORMATION

LAST NAME	FIRST NAME	SEX	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY#
		M F	____/____/____		
		M F	____/____/____		
		M F	____/____/____		
		M F	____/____/____		

EMPLOYEE SIGNATURE: _____ **DATE:** _____

I hereby authorize deductions from my salary of the amount required, if any, for the insurance indicated. This authorization will be in effect until revoked in writing. GSEHP insurance deduction is paid on a pre-tax basis unless a waiver form is submitted. (See *Graduate Student Benefits Handbook* for pre-tax medical insurance deduction information.)

EFFECTIVE DATE OF COVERAGE OR CHANGE:	COMMENTS:
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PROCESSOR: ORACLE _____ UMR _____ SCANNING _____