



INDIANA UNIVERSITY

Change of Status Form

Request to Change Benefit Enrollments
Step 1 of 2

INSTRUCTIONS: Changing your benefit enrollments is a two-step process.

Step 1 initiates the process and consists of completing and sending this Change of Status form to Human Resources, Poplars E165, IU Bloomington, fax to 812-855-3409, or scan and email to recben@indiana.edu.

Step 2 is when you request the actual change in plan coverage. Upon approving your Change of Status form, Human Resources will generate a personalized benefit enrollment form for you. You will complete your elections on this form and attach any required documentation. After you return the form, the HR office will finalize your status and benefit changes.

Note: Changes must be completed within 30 days of the Event Date

Name: _____

10-Digit University ID (not your SSN): _____
Also called Employee ID. This can be found by logging on to OneStart.

Campus: _____

Department: _____ Campus Phone: _____

Campus e-mail: _____

REASON(S) FOR CHANGE IN BENEFITS ENROLLMENT. Check any and all that apply.

| Event | Event Date | Documentation that will be required by Step 2 |
|--|--|--|
| FAMILY CHANGE | | |
| <input type="checkbox"/> Birth or adoption | | Copy of birth certificate or custody/adoption order |
| <input type="checkbox"/> Marriage of employee | | Copy of marriage certificate, and if dropping IU coverage, documentation of enrollment in spouse's plan. |
| <input type="checkbox"/> Divorce/Legal Separation | | Copy of part of the divorce showing date |
| <input type="checkbox"/> Termination of Domestic Partnership | | Copy of notarized Termination of Domestic Partnership |
| <input type="checkbox"/> Death of spouse/child | | Copy of death certificate |
| <input type="checkbox"/> Change in residence | <input type="checkbox"/> arrive/depart USA | Copy of passport or immigration documentation |
| | <input type="checkbox"/> other | Describe: |
| | | |
| <input type="checkbox"/> Dependent care provider or cost | | Letter from provider |

DEPENDENT CHILD CHANGE (Check the box that best describes the nature of the change)

| | | |
|---|--|---|
| <input type="checkbox"/> Reaches age 26 | | None needed |
| <input type="checkbox"/> Disabled child age 26 or above | | Certification of Disabled Dependent Child Eligibility |

COURT ORDER/GOVERNMENT PROGRAM CHANGE

| | | |
|--|--|---|
| <input type="checkbox"/> Guardianship or support order | | Copy of court order |
| <input type="checkbox"/> Medicare | | Written notice from government agency |
| <input type="checkbox"/> CHIP/Medicaid | | Written notice from government agency NOTE: Changes must be completed within 60 days of event date |

| Event | Event Date | Documentation that will be required by Step 2 |
|---|------------|--|
| WORK CHANGE | | |
| <input type="checkbox"/> Leave of absence <input type="checkbox"/> Begin <input type="checkbox"/> End | | None if IU; if not, documentation of date eligibility ends with spouse's employer |
| <input type="checkbox"/> Involuntary loss of outside coverage | | Notice from outside insurance provider of date or cover age ending, e.g. HIPAA coverage notice |
| <input type="checkbox"/> Begin spouse's employment/benefits at: <input type="checkbox"/> IU <input type="checkbox"/> Elsewhere | | None if IU; if not, written notice from spouse's employer |
| <input type="checkbox"/> Loss or change in spouse's employment or benefits: <input type="checkbox"/> IU <input type="checkbox"/> Elsewhere | | None if IU; if not, documentation of date eligibility ends with spouse's employer |
| <input type="checkbox"/> Significant change in premium cost (generally 10% or more) of spouse's coverage | | Written notice from spouse's employer |
| <input type="checkbox"/> Open enrollment at spouse's employer | | Written notice from spouse's employer |

COBRA: If you are submitting this form due to divorce/separation, end of domestic partnership, or child no longer eligible for coverage, please provide the address of the dependent as he/she may be eligible for continued coverage through COBRA.

Delivery of personalized benefit enrollment form (available in 3-5 days):

- Please mail to my CAMPUS address
- Mail to my HOME address.
- Email them to me at: _____
- I will pick up at the campus HR office (you will be notified when the form is ready)

Signature: _____

I understand that intentionally providing false information or statements will be grounds for IU to void my coverage and/or terminate my employment.