



RESEARCH ASSOCIATE/SCHOLAR FLORIDA BENEFITS COVERAGE CHANGE FORM

Name _____ ID# _____ Work Ext. _____ Email _____

Type of Change

ADD
 DROP

Date of Status Change

____/____/____

I certify that I am revising my plan elections **within 31 days** of my status change.

Reason for Change *

<input type="checkbox"/> Marriage <input type="checkbox"/> Registered Domestic Partners <input type="checkbox"/> Birth or adoption of a dependent <input type="checkbox"/> Change in your child(ren)'s, spouse's or domestic partner's health coverage (obtains or loses other coverage) <input type="checkbox"/> Change in dependent care expenses	<input type="checkbox"/> Divorce/ Legal Separation <input type="checkbox"/> Termination of Domestic Partnership <input type="checkbox"/> Dependent eligible due to full-time student status <input type="checkbox"/> Dependent reaching ineligible age/status (eligible up to age 19 or 25 if full-time student status) <input type="checkbox"/> Death of a dependent <input type="checkbox"/> Dependent entering/leaving the country
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*** Please note, in addition to Proof of Dependency, Proof of Status Change may be required.**

Changes: (Indicate below the changes that are consistent with your status change.)

<i>Medical Coverage</i>	<i>Elect a plan choice <u>only</u> if a new enrollee</i>
<input type="checkbox"/> Waive Coverage* <input type="checkbox"/> Research Assoc. Only <input type="checkbox"/> Research Assoc.+Child(ren)** <input type="checkbox"/> Research Assoc.+Spouse** <input type="checkbox"/> Research Assoc.+Domestic Partner** <input type="checkbox"/> Research Assoc.+Family** <input type="checkbox"/> Research Assoc.+Child(ren)+Domestic Partner**	<input type="checkbox"/> Comprehensive Plan <input type="checkbox"/> HMO Plan † <input type="checkbox"/> Catastrophic Plan

<i>Dental Coverage – Delta Dental</i>
<input type="checkbox"/> Waive Coverage <input type="checkbox"/> Research Assoc. Only <input type="checkbox"/> Research Assoc.+Child(ren)** <input type="checkbox"/> Research Assoc.+Spouse** <input type="checkbox"/> Research Assoc.+Domestic Partner** <input type="checkbox"/> Research Assoc.+Family** <input type="checkbox"/> Research Assoc.+Child(ren)+Domestic Partner*

† If you are enrolling in or adding dependents to the HMO Medical Plan you will need to fill out a Primary Care Physician Designation Form.

<i>Flexible Spending Account</i>	<i>Dependent Care Spending Account</i>
	<input type="checkbox"/> No Change <input type="checkbox"/> New Benefit Election goal amount per year \$ _____

List only those individuals you are adding/dropping to the medical, and/or dental insurance plans:

Name: _____	Birthdate: _____	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dom Partner	<input type="checkbox"/> Child
		<input type="checkbox"/> Add	<input type="checkbox"/> Drop	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental		
Name: _____	Birthdate: _____	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dom Partner	<input type="checkbox"/> Child
		<input type="checkbox"/> Add	<input type="checkbox"/> Drop	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental		
Name: _____	Birthdate: _____	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dom Partner	<input type="checkbox"/> Child
		<input type="checkbox"/> Add	<input type="checkbox"/> Drop	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental		

* If I elect to decline coverage under the medical plan, I understand that I am required to sign a "Proof of Other Coverage" statement. I further understand that by waiving coverage I am not able to add coverage unless I incur a qualified status change. I understand I must notify Human Resources within 31 days of the date of the qualified status change in order to make a change in my elections. **I understand proof of dependency is required for any dependent children and proof of marriage or domestic partnership is also required. If I elect the Dependent Care Spending Account, I understand that any unused balance will be forfeited at year-end. Except for election changes to your health plan coverage due to birth, adoption or placement for adoption, your change in election will be effective on the first day of the next administratively possible pay period following the date you submit a properly signed and completed Benefits Coverage Change Form and Proof to Human Resources. Election changes due to birth, adoption, or placement for adoption will be effective on the date of the child's birth, adoption or placement for adoption provided you submit a properly signed and completed Benefits Coverage Change Form and proof to Human Resources within 31 days of the date of the child's birth, adoption, or placement for adoption. Claims for services provided prior to the effective date of your election change will be based on your election in effect prior to such effective date. I authorize any payroll deduction that may be required as a result of the changes I have indicated on this form and hereby elect to receive the coverage for myself and my dependents selected herein at the applicable premium rates. I authorize my participation in the tax-free program by my signature below. If I elect to pay with after-tax dollars, I will write "after-tax" after my signature below. If my foreign visa or employment status precludes me from participating on a tax-free basis, I understand that my deductions will be taken on an after-tax basis. The first deduction for the new amount will occur on the first pay date after the form is signed and received by Human Resources.

Signature: _____ Date: _____

Return this form to 10550 North Torrey Pines Rd, TPC-11, La Jolla, CA 92037 or fax to 858-784-8071.

<i>Office Use Only</i>	Div.: _____	Pretax: _____	PPOL: _____	By: _____	Effective Date: _____
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