RESEARCH ASSOCIATE/SCHOLAR
CALIFORNIA 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 *

❑ Marriage	❑ Divorce/ Legal Separation
❑ Registered Domestic Partners	❑ Termination of Domestic Partnership
❑ Birth or adoption of a dependent	❑ Dependent eligible due to full-time student status
❑ Change in your child(ren)'s, spouse's or domestic partner's health coverage (obtains or loses other coverage)	❑ Dependent reaching ineligible age/status (eligible up to age 19 or 25 if full-time student status)
	❑ Death of a dependent
❑ Change in dependent care expenses	❑ Dependent entering/leaving the country

*** 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.)

Medical Coverage †	*Elect a plan choice only if a new enrollee*	*Dental Coverage – Delta Dental*
❑ Waive Coverage*	❑ Comprehensive Plan	❑ Waive Coverage
❑ Research Assoc. Only	❑ HMO Plan †	❑ Research Assoc. Only
❑ Research Assoc.+Child(ren)**	❑ Catastrophic Plan	❑ Research Assoc.+Child(ren)**
❑ Research Assoc.+Spouse**		❑ Research Assoc.+Spouse**
❑ Research Assoc.+Domestic Partner**		❑ Research Assoc.+Domestic Partner**
❑ Research Assoc.+Family**		❑ Research Assoc.+Family**
❑ Research Assoc.+Child(ren)+Domestic Partner**		❑ 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.

Flexible Spending Account	*Dependent Care Spending Account* ❑ No Change ❑ 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: ___________ ❑ M ❑ F ❑ Self ❑ Spouse ❑ Dom Partner ❑ Child
❑ Add ❑ Drop ❑ Medical ❑ Dental

Name: ____________________ Birthdate: ___________ ❑ M ❑ F ❑ Self ❑ Spouse ❑ Dom Partner ❑ Child
❑ Add ❑ Drop ❑ Medical ❑ Dental

Name: ____________________ Birthdate: ___________ ❑ M ❑ F ❑ Self ❑ Spouse ❑ Dom Partner ❑ Child
❑ Add ❑ Drop ❑ Medical ❑ 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 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.

Office Use Only	**Div.:**____________	**Pretax:** ____________	**PPOL:** ____________	**By:**____________	**Effective Date:**____________