



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 your campus HR office.

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 on your paycheck.

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"/> Domestic Partnership <input type="checkbox"/> Begin <input type="checkbox"/> End		Copy of notarized Affidavit of Domestic Partnership or 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 <input type="checkbox"/> other		Copy of passport or immigration documentation
		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"/> Marriage of child		Copy of marriage certificate
<input type="checkbox"/> Tax Dependent Status <input type="checkbox"/> Begin <input type="checkbox"/> End		Certification of Eligibility for Dependent Child Age 19 or Older
<input type="checkbox"/> Reaches age 24		None needed
<input type="checkbox"/> Disabled child age 19 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
- 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.