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:**	**EE #** **SCHOOL ID #**

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

DATE OF BIRTH	**SEX CODE**	**MARITAL CODE**
_____/______/_____	M ☐ F☐	SINGLE☐ MARRIED☐ → MARRIAGE DATE ___/___/_____

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** ☐

DEPARTMENT NAME & ZIP	**EMAIL ADDRESS:**	**VISA TYPE : F1** ☐ **J1** ☐

ENTER REQUEST BELOW (CHECK ONE BOX)

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

REASON FOR CHANGE

☐**CHANGE TO FAMILY**	☐ **MARRIAGE** _____________
☐**CHANGE TO INDIVIDUAL**	☐ **NEW BORN** _____________
☐**ARRIVAL OF ELIGIBLE DEPENDENT IN UNITED STATES**	☐ **SPOUSE COVERAGE ENDED**________
☐**REQUEST COVERAGE FOR DEPENDENTS**	☐ **OTHER**______________________
☐**REQUEST FOR DOMESTIC PARTNER HEALTH INSURANCE**	

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**:

PROCESSOR:	ORACLE ☐____________ UMR ☐ ____________ SCANNING ☐ ___________