



## INSTRUCTIONS

You must download this form to your computer to make it a fillable PDF. Please save the filled-out document to your PC before uploading to the Secure Document Portal.

1. A Family Status Change form (FSC) must be completed if you have experienced a change in family status (marriage, birth of a child, adoption, divorce, death of a spouse or child, etc.) and would like to make changes. The completed form must be returned to the HR-Benefits department within 30 days of the event date. If this form is not received within 30 days, the change in benefit coverage cannot take place until the next annual open enrollment.
2. Please complete pages 2 and 3 of the FSC form only indicating the name(s) and desired change(s). The change must be consistent with your status change.
3. Specific documentation other than this FSC form may be required for certain changes. Please refer to the Acceptable Supporting Documentation section below.
4. Return the completed form and supporting documentation (if applicable) to the HR-Benefits department: 550 S. College Ave., Suite 201 or email hrhelp@udel.edu. Or upload to our Secure Document Portal.
5. Please contact Human Resources-Benefits by email (hrhelp@udel.edu) or phone (302) 831-2171 with any questions about this form or your benefits.

## IMPORTANT REMINDERS

Remember to update beneficiaries for Basic Life Insurance and Retirement benefits.

[MetLife Beneficiary Designation](#)

[TIAA Beneficiary form](#)

[State Pension Personal Information Form \(P-1\)](#)

Event	Documentation/Forms Required
<b>Change in marital status:</b> Marriage	Marriage Certificate Social Security Card <a href="#">State of Delaware Spousal Coordination form</a>
<b>Divorce</b>	Divorce Decree
<b>Change in number of dependents:</b> Birth Adoption Become a step parent	Adoption Certificate Birth announcement/Birth Certificate <a href="#">Aetna -Dependent Coordination form (DCOB)</a> <a href="#">Highmark-Dependent Coordination form (DCOB)</a> Social Security Card
<b>Death</b>	Death Certificate
<b>Change in employment status:</b> Employee (part-time, leave of absence) Spouse/Dependent child (new employment, leave of absence, termination of employment, etc.)	<b>Loss of employment/coverage</b> Letter of employment listing the effective date of new health insurance

Employees can review their current benefits coverage level in Web Views under Flex Benefits View to ensure changes are reflected correctly. You must download this form to your computer to make fillable.



Employee Personal Information: Please print/type all information

Name: \_\_\_\_\_

Employee ID : \_\_\_\_\_

Work Phone : \_\_\_\_\_ Home Phone: \_\_\_\_\_

Effective Date of Family Status Change: \_\_\_\_\_

**Reason for Family Status Change**

- Marriage       Divorce     Death of spouse or dependent     Birth or Adoption of Child
- Change in Spouse's employment     Change in percent time worked     Change in child's eligibility
- Moving out of HMO service area     Other

Explanation Required: \_\_\_\_\_

**Action:**    Add Coverage     Remove Coverage

Dependent Information: If you are removing a dependent, please provide the dependent's current address:

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Street
City
State
Zip

DEPENDENT INFORMATION				
Spouse/Dependent Name(s)	Gender	Social Security #	Birth Date	Relationship

PLAN/COVERAGE LEVEL CHANGES ONLY					
MEDICAL		DENTAL		VISION	
<input type="radio"/> First State Basic	<input type="radio"/> Employee	<input type="radio"/> MetLife	<input type="radio"/> Employee	<input type="radio"/> NVA	<input type="radio"/> Employee
<input type="radio"/> Aetna CDH Gold	<input type="radio"/> Empl. & Spouse	<input type="radio"/> Waive	<input type="radio"/> Empl. & Spouse	<input type="radio"/> Waive	<input type="radio"/> Empl. & Spouse
<input type="radio"/> Aetna HMO	<input type="radio"/> Empl. & Children		<input type="radio"/> Empl. & Children		<input type="radio"/> Empl. & Children
<input type="radio"/> Highmark Comprehensive PPO	<input type="radio"/> Family		<input type="radio"/> Family		<input type="radio"/> Family
<input type="radio"/> Waive					

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BASIC LIFE INSURANCE - METLIFE	LONG TERM DISABILITY	FLEXIBLE SPENDING ACCOUNTS
<input type="radio"/> \$10,000 <input type="radio"/> \$50,000 <input type="radio"/> 2x's benefits base salary	<input type="radio"/> Standard Option <input type="radio"/> High Option	<input type="radio"/> Healthcare total for calendar year _____ <input type="radio"/> Waive <input type="radio"/> Dependent (Day) Care total for calendar year _____ <input type="radio"/> Waive

**Changes During the Year:** You can change your coverage between annual enrollments only if you have a change in status, as defined by federal law. A change in status happens when: you marry, divorce or legally separate; a child joins your family through birth or adoption; your spouse becomes employed, loses his or her job (full-time employment) or involuntarily loses medical coverage; your spouse or dependent child dies; your dependents become ineligible for coverage; you or your spouse have a change in job status from full-time to part-time or vice versa; you or your spouse take an unpaid leave of absence; you or your spouse have a significant change in health coverage due to a change in your spouse's employment. If you have a change in status, you have 30 days to change your coverage. Furthermore, the requested change must be consistent with the event.

**Spousal Coordination of Benefits Policy:** If you are covering your spouse under a University health plan, we also want to share some very important information with you about the Spousal Coordination of Benefits Policy. This policy affects how health insurance benefits payments are made for a spouse who is eligible for, but not enrolled in, coverage through their employer. According to this policy, if your spouse works full-time and would pay 50% or less of the total premium for individual coverage (premium based on the lowest-cost individual plan available through their employer), s/he must enroll in their employer's health plan. If your spouse meets the above criteria, but does not enroll in his/her employer's health plan, the University's plan will pay 20% of allowable charges.

Misinterpretation and/or failure to comply with this policy may have significant financial implications for you. If applicable, please take a few minutes to read this policy and sign the [Spousal Coordination of Benefits policy form](#). Information on this form is shared with Statewide Benefits and is used to verify your spouse's access to health insurance.

**Basic Employee Life Insurance:** You can change your Basic Life coverage between annual enrollments only if you have a change in family status.

**Optional Life Insurance:** Changes to your Optional Life insurance coverage can be made at any time during the year. In addition, with a change in family status, you may be eligible to enroll in or increase coverage for one of the Optional Life Insurance options through MetLife.

Please note that certain levels of coverage for yourself and/or your spouse may require that you and/or your spouse provide proof of good health. If, as a result of the change in family status, you must cancel Optional Life for your spouse or dependent children, you should contact MetLife directly. To enroll go to: <http://www1.udel.edu/metlife-auth>. For information contact MetLife Customer Service at 1-866-492-6983.

**Health Plan Authorization:** I understand that rights to service are subject to acceptance of my enrollment and to the terms and conditions specified in the present contract between the health insurance carrier and the State of Delaware. I certify that all information supplied by me is true. I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents to the health insurance carrier or its designee for purposes reasonably related to their contract or as required by law.

I authorize the University to collect premium contributions by payroll deduction or otherwise, for remittance to applicable benefit carriers.

I have read and agree with the above terms.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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