

ENROLLMENT FORM FOR GRADUATE STUDENT EMPLOYEES/FELLOWS AND THEIR DEPENDENTS

<input type="checkbox"/> NEW <input type="checkbox"/> RE-APPOINTED <input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> DELETE DEPENDENT <input type="checkbox"/> TERMINATE <input type="checkbox"/> ADDRESS CHANGE <input type="checkbox"/> CARD REQUEST					
LAST NAME:		FIRST NAME:		SOCIAL SECURITY #	
MAILING ADDRESS:		CITY:	STATE:	ZIP:	
DATE OF BIRTH ____/____/____	SEX CODE M <input type="checkbox"/> F <input type="checkbox"/>	MARTIAL CODE SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> → 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 <input type="checkbox"/>		
DEPARTMENT NAME & ZIP		EMAIL ADDRESS:			VISA TYPE : F1 <input type="checkbox"/> J1 <input type="checkbox"/>
ENTER REQUEST BELOW (CHECK ONE BOX)					
<input type="checkbox"/> I DECLINE COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> INDIVIDUAL +1 <input type="checkbox"/> INDIVIDUAL +2 OR MORE					
REASON FOR CHANGE					
<input type="checkbox"/> CHANGE TO FAMILY <input type="checkbox"/> CHANGE TO INDIVIDUAL <input type="checkbox"/> ARRIVAL OF ELIGIBLE DEPENDENT IN UNITED STATES <input type="checkbox"/> REQUEST COVERAGE FOR DEPENDENTS <input type="checkbox"/> REQUEST FOR DOMESTIC PARTNER HEALTH INSURANCE			<input type="checkbox"/> MARRIAGE _____ <input type="checkbox"/> NEW BORN _____ <input type="checkbox"/> SPOUSE COVERAGE ENDED _____ <input type="checkbox"/> OTHER _____		
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 <i>Graduate Student Benefits Handbook</i> for pre-tax medical insurance deduction information.)					
EFFECTIVE DATE OF COVERAGE OR CHANGE:			COMMENTS:		
PROCESSOR:		ORACLE <input type="checkbox"/> _____ POMCO <input type="checkbox"/> _____ SCANNING <input type="checkbox"/> _____			