



Notification of Family Status Change Form (Requested changes must be consistent with the qualifying event)

Employee ID or Social Security # Last Name First Name M.I. Date of Birth
Home Mailing Address City State Zip
Daytime Phone Number Department Email

Qualifying Event

Note: You must attach documentation and submit within 30 days of the qualifying event triggering the need for the insurance change.

- Marriage/Divorce/Domestic Partner Certification*
Birth or Adoption
Death
Employment Change
Qualified Court Ordered Child Support
Other

Health

Health Option* (Choose One):
Health Coverage Level:
Aetna Standard
Aetna HealthFund
BlueCross Advantage P
Waive (attach required waiver)
Self
Self + Spouse
Self + Certified Partner1
Self + Children
Family

* Your original health option and dental plan must be maintained throughout the plan year.

Dental (Optional)

Dental Plan* (Choose One):
Dental Coverage Level:
CIGNA Dental PPO
CIGNA Dental Care (DHMO)
DHMO facility number:
Self
Self + Spouse
Self + Certified Partner1
Self + Children
Family
Waive

(If you do not indicate a facility, one will be assigned to you.)

VSP Vision (Optional)

Vision Coverage Level:
Self
Self + Spouse
Self + Certified Partner1
Self + Children
Family
Waive

Family Members (By including your spouse/certified partner and/or children, you assert they meet eligibility requirements. Attach second sheet if necessary.)

Table with columns: Add/Delete, Last Name, First Name, Relationship, Social Security #, Date of Birth, Gender, Enroll In. Includes checkboxes for M, F, Health, Dental, Vision.

Accidental Death & Dismemberment

Coverage Amount (in \$10,000 increment) \$ Coverage Level Individual Family Waive
(If you enter an amount greater than 10x your salary, the amount will be lowered to 10x your salary. To change your beneficiary, use Beneficiary Change Form)

When declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be eligible to enroll yourself or your dependents in the Vanderbilt Plan provided you request enrollment within 30 days of the qualifying event that causes the coverage change.

I have received and understand information about Vanderbilt University's benefit program. I choose to enroll and/or waive as indicated above. I understand waiving out of Vanderbilt's Health Plan for Faculty and Staff eliminates my participation in the Flexible Reimbursement Account (FRA).

Benefits Office Use Only
Pay Group
ID #
Eff Date
Group #
Date Received in Benefits

Employee Signature Date

Note: If you wish to change your life insurance, beneficiaries, or personal spending accounts (PSAs), you must complete additional forms.

1 For domestic partner certification, you must contact the Office of the Director of Benefits to set an appointment.

Submit supporting documentation and original form to: Vanderbilt HR, Benefits, VU Station B #357700, 2301 Vanderbilt Place, Nashville, TN 37235-7700. Keep a copy of this form for your records.