STATE OF DELAWARE GROUP HEALTH INSURANCE PROGRAM
Enrollment and Verification Form for Double State Share (DSS) Coverage

Completion of this form is required to ensure compliance with DSS plan eligibility.

IMPORTANT – FOLLOW THE STEPS BELOW:

Step 1 – Complete this form to verify your DSS eligibility. One form must be completed for each contract of health plan coverage (if you and your spouse are enrolled in separate health plans, each of you will need to complete this form).

Step 2 – Return the completed form to Human Resources Benefits Office:

- **Scan and e-mail to hrhelp@udel.edu;**
- **Fax to (302) 831-1482; or**
- **Mail to Human Resources-Benefits, 413 Academy Street, Newark, DE 19701**

Section I - Employee Information

Employee Name: ____

Employee ID: ________________________

Section II - Spousal Information

Name of Spouse: ____________________________________

Date of Marriage (mm/dd/yyyy): _________________________________

Select from the following for spouse's ***CURRENT*** status:

- ☐ State of DE Employee
  - Employing Agency/School District/Charter School: ________________________
  - Employee ID: _________________
- ☐ Delaware Transit Corporation Employee
- ☐ DE Solid Waste Authority Employee
- ☐ University of DE Employee; Employee ID: ____________________
- ☐ DE State Housing Authority Employee
- ☐ Spouse is ***CURRENTLY*** working for an employer other than the State of DE or one of the groups indicated above.
  - Current Employer:__________________________________
  - Employee ID (if applicable): ________________________
  - Is spouse in a full time benefit eligible position? Yes ☐ No ☐

  Please indicate below, which State of DE or group listed above that your spouse last worked for as a full-time benefit-eligible employee (if applicable):
  - Employing Agency/School District/Charter School: ________________________
  - Employee ID (if applicable): _________________
- ☐ State of DE Pensioner on Long-Term Disability
  - Pensioner ID:_______________(enter Spouse SSN if Pensioner ID is not known)
- ☐ State of DE Pensioner
  - Pensioner ID:_______________(enter Spouse SSN if Pensioner ID is not known)
  - Is spouse currently receiving a State of DE pension check? Yes ☐ No ☐
- ☐ Spouse is no longer employed by the State or any group indicated above
  - Date of separation: __________________
- ☐ Spouse is deceased

  Are you receiving a survivor's pension? Yes ☐ No ☐

CERTIFICATION (everyone must sign and date)

By my signature below, I hereby certify the statements made on this form are true. I understand that I may be required to provide copies of my marriage certificate and/or birth certificates for dependents enrolled in my DSS health plan coverage as required by my Human Resources Benefits Office.

EMPLOYEE SIGNATURE:____

(Please print this form, sign and return to your HR/Benefits Office)

DATE (mm/dd/yyyy): _________________________