



Retiree Family Status and Benefit Change Form

Please complete this benefits change form if you have experienced a change in family status (marriage, birth of a child, adoption, divorce, death of a spouse or child, etc.) as the benefits you chose at the beginning of the plan year may be affected. Return the signed form within 30 days of the event to hrhelp@udel.edu or through the [Secure Document Submission](#) site. Please contact us with any question about this form or your benefits.

To view your current benefits, log in to [Web Views](#) and select Flexible Benefits View under the Self-Service Section:

Demographic information – Please help us keep your records current. Fill in your name, employee ID number, address, and phone number, then identify any other information that has changed.

Name: _____ Employee ID: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Date of Event: _____

UD Email: _____ Alternate Email: _____

Family Status Change – Indicate the family status change by marking an selecting in the appropriate change with an “X”:

Marriage		Divorce		Death of spouse or dependent	
Birth or Adoption of child		Change in spouse’s employment		Change in your percent time worked	
Change in child’s eligibility		Moving out of service area			
Medicare eligible		Other, Explanation Required			

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

_____ Street _____ City _____ State _____ Zip _____

Action	Spouse/Dependent Name(s)	Gender	SSN	DOB	Relationship	Primary Care Physician (Aetna HMO, only)
Add						
Remove						
Add						
Remove						

Please note–documentation is required when initially enrolling a dependent under a health plan. This includes a marriage certificate when covering a spouse, and birth or adoption certification when covering a dependent child(ren) and a copy of their social security card.

CHECK ONLY THE BENEFITS YOU ARE CHANGING

Medicare Plan Selections	
Name: _____ Please indicate your coverage election below with an “X”	
<input type="checkbox"/>	Highmark Blue Cross Blue Shield Delaware Special Medicfill WITH Prescription
<input type="checkbox"/>	Highmark Blue Cross Blue Shield Delaware Special Medicfill WITHOUT Prescription
<input type="checkbox"/>	Waive – Medical/Prescription Coverage
Non-Medicare Plan Selections	
Name: _____ Please indicate your election below with an X:	
<input type="checkbox"/>	Aetna CDH Gold
<input type="checkbox"/>	Highmark Blue Choice Deductible PPO
<input type="checkbox"/>	Aetna HMO
<input type="checkbox"/>	Highmark Blue Choice PPO
<input type="checkbox"/>	Waive

Please indicate your coverage election below with an "X":			
	Individual		Individual & Child(ren)
	Individual & Spouse		Family

Dental Plan Selections		Vision Plan Selections	
Please indicate your coverage election below with an "X":		Please indicate your coverage election below with an "X":	
	MetLife Core Dental		Enroll
	MetLife Enhanced Dental		Waive
Please indicate your level election below with an "X":		Please indicate your level election below with an "X":	
	Individual & Spouse		Individual & Child(ren)
	Individual		Family

Changes during the year

Please know that you may be eligible to change your coverage between annual enrollments only if you have a change in status such as: 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; your spouse takes 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, or you become eligible for Medicare. If you have a change in status, you have **only 30 days** to change your coverage. Furthermore, the requested change must be consistent with the event.

Working Spouse Surcharge Program

If you are covering your spouse under a university health plan, please review the **Working Spouse Surcharge Program**. This program affects how health insurance benefits payments are made for a spouse who is eligible for coverage through their current or former employer. To help offset the cost of covering a spouse who has access to other employer-sponsored medical plans, UD may apply a surcharge to retirees who enroll their spouse in coverage. To determine the applicability of the surcharge, you are required to complete the **Working Spouse Surcharge Verification form**. A monthly surcharge will apply to retirees who elect to cover a spouse meeting the criteria outlined below.

Retirees who choose to enroll a spouse in the University's medical plan may be subject to a \$200 per month surcharge if:

- The spouse is eligible for group medical coverage through their current employer and is responsible for 50% or less of the premium for the lowest cost employee only plan available to them but chooses to enroll in UD's plan instead, or as primary coverage; or
- The spouse is retired and has access to a health plan through their former employer or retirement plan and is responsible for 50% or less of the premium for the lowest retiree-only plan available to them but chooses to enroll in UD's plan instead, or as primary coverage. This surcharge is in addition to the standard medical premium.

Retiree Life Insurance

Retiree life insurance is administered by MetLife. Please contact MetLife Customer Service at 1-866-492-6983 with any questions or changes regarding billing, coverage, or beneficiary designations.

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 have read and agree with the above terms and authorize the University to collect premium contributions for remittance to applicable benefit carriers.

_____	_____
Signature (Participant)	Date
_____	_____
Signature (Spouse of Participant)	Date

If you have questions regarding this form or your benefits, please contact HR at hrhelp@udel.edu or call 302-831-2171. Please return your completed form to hrhelp@udel.edu or our [Secure Document Submission](#) site.