



# Brandeis University

Office of Human Resources  
MS 118 – Benefits section

781.736-4467  
781.736-4466(fax)

## Benefit Change or Cancellation Form

Empl ID: \_\_\_\_\_

### Employee Information

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

Extension: \_\_\_\_\_

Department / MS#: \_\_\_\_\_

Email: \_\_\_\_\_

**Employment Status:**  Faculty (FAC)  Postdoctoral Fellow (FAC)  Exempt (EXS)  Library Exempt Union (EXS)  
(Please check one)  Non-Exempt (NEX)  Non-Exempt Union (UNE)  Police Services Union (PSU)

**Action Requested:**  Change of Benefit Coverage  Cancellation of Benefit(s) **Effective Date:** \_\_\_\_\_, 20\_\_

### Qualifying Event for Change or Cancellation

Please check the Qualifying Event for your change and/or cancellation of Health and/or Dental Insurance only. (Please check one reason only)

**\*Please provide the following documentation:** Proof of insurance, marriage certificate, divorce/separation agreement or adoption paperwork, etc.

- I have other coverage through my spouse/domestic partner\*
- My spouse/partner has other coverage for himself/herself\*
- My dependent is no longer eligible
- Change in legal marital status\*
- Adoption/Adoption placement paperwork \*
- Death of spouse/partner/dependent
- Relocation outside of service area
- Unpaid Leave of Absence
- Other permissible event\*
- Open Enrollment**

### Health Insurance

**Please note:** if you are canceling coverage for yourself you **must complete a HIRD form.** \*List spouse and/or dependent(s) on back. \*\*Please complete application to add dep.

Current Plan

- Tufts Premium HMO
- Tufts Value HMO
- Tufts PPO

Current Coverage

- Single
- Family

Action

- Cancel
- Remove Spouse\*
- Remove Dependent\*
- Change my plan from Family to Single
- Add dependent\*\*

### Dental Insurance

**\*Please list spouse and/or dependent(s) on the back of this form.** \*\*Please complete application to add dependent(s).

Current Plan

- DeltaCare
- Delta PPO + Premier

Current Coverage

- Single
- Family

Action

- Cancel
- Remove Spouse\*
- Remove Dependent\*
- Change my plan from Family to Single
- Add dependent\*\*

### Documentation

If you need documentation for your dependent(s), please list the name(s) and address(es) of dependent(s) on the back

- A letter verifying termination of coverage
- COBRA- coverage continuation packet

### Supplemental Life Insurance

I understand that if I want to resume this insurance in the future, I will have to apply to the Life Insurance Carrier for approval.

- \$20,000
- \$50,000
- \$100,000
- \$200,000

**Date of Cancellation:** \_\_\_\_\_  
Must be last day of month

### Please Sign Below

In the event of cancellation of benefits, I understand that I will not be able to resume my health and dental insurance except if I have a qualifying event or during the Brandeis University Annual Open Enrollment Period in November with coverage effective January 1<sup>st</sup>.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

#### For Internal Use

Received by: \_\_\_\_\_ Date: \_\_\_\_\_  PeopleSoft \_\_\_\_\_  W/F/M/E \_\_\_\_\_

- proof of coverage
- marriage certificate
- divorce/separation agreement
- adoption paperwork
- HIRD form
- other

## Dependent Information

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Name

Address

Name

Address

Name

Address

Name

Address

Name

Address

Name

Address