



ENROLLMENT FORM FOR GRADUATE STUDENT EMPLOYEES/FELLOWS AND THEIR DEPENDENTS

NEW FELLOW RE-APPOINTED ADD DEPENDENT DELETE DEPENDENT TERMINATE ADDRESS CHANGE CARD REQUEST

LAST NAME:	FIRST NAME:	SOCIAL SECURITY #
		SCHOOL ID #

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 ____/____/____
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HOME PHONE #	WORK PHONE#	CELL PHONE#	Have you been enrolled in the TA/GA health insurance within the last 28 days? If yes check box <input type="checkbox"/>
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DEPARTMENT NAME & ZIP	EMAIL ADDRESS:	VISA TYPE : F1 <input type="checkbox"/> J1 <input type="checkbox"/>
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ENTER REQUEST BELOW

INDIVIDUAL **INDIVIDUAL +1** **INDIVIDUAL +2 OR MORE**

REASON FOR CHANGE

<input type="checkbox"/> CHANGE TO FAMILY	<input type="checkbox"/> MARRIAGE _____
<input type="checkbox"/> CHANGE TO INDIVIDUAL	<input type="checkbox"/> NEW BORN _____
<input type="checkbox"/> ARRIVAL OF ELIGIBLE DEPENDENT IN UNITED STATES-VISA TYPE _____	<input type="checkbox"/> SPOUSE COVERAGE ENDED _____
<input type="checkbox"/> REQUEST COVERAGE FOR DEPENDENTS	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> REQUEST FOR DOMESTIC PARTNER HEALTH INSURANCE	

DEPENDENT INFORMATION

LAST NAME	FIRST NAME	SEX	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY#
		M F	____/____/____		
		M F	____/____/____		
		M F	____/____/____		
		M F	____/____/____		

EMPLOYEE SIGNATURE: _____ **DATE:** _____

AGENCY USE ONLY- STONY BROOK 050

EFFECTIVE DATE OF COVERAGE OR CHANGE:	COMMENTS:
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PROCESSOR:
ORACLE _____ POMCO _____ SCANNING _____