BENEFITS ACTION FORM

NAME ______________________ DATE OF BIRTH ______________________

1. Action (check one):	☐ Benefits Enrollment/Change ☐ Leave of Absence ☐ Termination ☐ Miscellaneous
2. Benefits Selection **a. enter date** **b. choose action** **c. check insurance plan**	Coverage for the Following: Effective Date: ________________ Action: Begin/Change/Stop ☐ Blue Cross ☐ Kaiser ☐ Dental ☐ Vision ☐ FSAP
3. Employee/Dependents/ LDA	Complete this section to, (1) add or drop an eligible family member in the medical, dental, vision plans or (2) change personal data (i.e. change name). If you are adding or dropping family members, show the date of the event (marriage, birth, adoption, divorce, death or termination of Legally Domiciled Adults ("LDA") relationship - in the first column below, circle "A" for Add or "D" for Drop and check the appropriate insurance plan check box in the Medical/Dental/Vision/FSAP column. Enter the appropriate code to indicate the family member's relationship to you. You may only enroll either a Spouse or an adult LDA. You may also enroll a Dependent Child(ren) and/or LDA Child(ren). **Relationship Codes: Spouse (S)** or **LDA (D) Dependent Child(ren) (C) or LDA Child(ren) (K).**

Circle A / D Below	Qualifying Date			Name (Last, First, MI)	Sex	Relationship (use codes)	D.O.B.			Social Security #	Medical/Dental/Vision/FSAP
ADULTS:											
	M	D	Y			self	M	D	Y		
A											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
D											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
	M	D	Y				M	D	Y	Required (S) (D)	
A											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
D											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
CHILDREN:											
	M	D	Y				M	D	Y	Required (C) (K)	
A											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
D											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
	M	D	Y				M	D	Y	Required (C) (K)	
A											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
D											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
	M	D	Y				M	D	Y	Required (C) (K)	
A											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
D											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
	M	D	Y				M	D	Y	Required (C) (K)	
A											☐ Medical ☐ Dental ☐ Vision ☐ FSAP
D											☐ Medical ☐ Dental ☐ Vision ☐ FSAP

I certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in the USF Group Insurance Eligibility Factsheet. I agree that I will remove them within 31 days if they lose eligibility. I further certify that all the information provided is true to the best of my knowledge, under penalty of perjury.

Making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility within 31 days, or failing to provide documentation when requested may lead to a termination of the family members and to legal action. In addition, employees will be subject to disciplinary action (i.e. loss of health benefits for 18 months) and will be responsible for any employer contributions to and benefits paid by the plan.

Signature ______________________________ Date:______________

4. Miscellaneous:	Effective Date:	Begin/Change/Stop the deduction for
		in the amount of $ per pay period
5. Remarks:		

Name (Print): ____________________________ Signature __________________________ Date:_________

HR Representative: ________________________ Date:_________