University of Florida, College of Medicine
Change of Status Form/Group Health Insurance Policy #2658
Please return completed form to Fringe Benefits, Box 100014

Department: ______________Faculty ☐ Housestaff ☐ Family ☐ Single ☐
Account/Affiliate # ______________________________(to be completed by Dean's Office)

Name of Employee:____________________________________SS#:______________________
Date of Hire:

Change of Address: ____
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Date of Change:

Employee Changes:
Single to Family ☐ Family to Single ☐ Transfer Accounts ☐ Termination ☐

Date: Reason:

Dependent Changes: Add ☐ Delete ☐
Spouse ☐ Child ☐ Stepchild ☐ Adopted child ☐
Date:_____________________Reason:____
Name:_________________Sex_____Relationship____ dob_____________SS#_______________
Name:_________________Sex_____Relationship____ dob_____________SS#_______________
Name:_________________Sex_____Relationship____ dob_____________SS#_______________
Name:_________________Sex_____Relationship____ dob_____________SS#_______________
Full Time Student Age 19 or over? Yes/No ___ Name of School: __________________________
Spouse's Employer:_________________Address_________________Phone________________
Other health insurance coverage? Yes/No _____ Group/ Individual ______
Name of Insurance Company____
Policy #__________Effective date:________Claims Office:______________________________

ADDITIONAL INFORMATION:
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Prepared by: ____Date______________________________

(Dean's Office Use Only: Received by:_____________Date_____________________________
Date sent to Holloway Financial______________________________
Revised 4/2000