# University of Florida College of Medicine
# Change of Status Reporting Form

Affiliate#_____ Affiliate#_____ Affiliate#_____ Affiliate#_____

☐ **Faculty/Gainesville** ☐ **Faculty/Jacksonville** ☐ **Housestaff/Gainesville** ☐ **Housestaff/Jacksonville**

**Department:**_____

**Name of Employee:** _____ **UFID#**_____ **HireDate:** _____

**Change of Address:**

**Coverage Changes:** ☐ **Single to Family** ☐ **Family to Single** ☐ **Transfer Accounts** ☐ **Term Coverage**

**Date:**_____ **Reason:**_____

**Dependent Changes:** ☐ **Add** ☐ **Delete** ☐ **Spouse** ☐ **Domestic Partner** ☐ **Child** ☐ **Stepchild** ☐ **Adopted Child**

**Date:**_____ **Reason:**_____

**Name:**_____ **Male/Female**_____ **Relationship**_____ **Birthdate**_____ **SocSec#**_____

**Name:**_____ **Male/Female**_____ **Relationship**_____ **Birthdate**_____ **SocSec#**_____

**Name:**_____ **Male/Female**_____ **Relationship**_____ **Birthdate**_____ **SocSec#**_____

**Full Time Student Age 19 or over?** ☐ **Yes** ☐ **No** **Name of School**_____

**Spouse/Domestic Partner employer:**_____ **Address**_____
**Other health coverage?** ☐ **Yes** ☐ **No** ☐ **Group** ☐ **Individual**
**Name of insurance company**_____ **Policy #**_____ **Effective Date:**_____
**Claims Office Address:**_____

**REMARKS/ADDITIONAL INFORMATION:**

**PREPARED BY:**_____ **DATE**_____ **DEAN'S OFFICE**_____ **DATE**_____

**PLEASE SUBMIT TO:Fringe Benefits/Gainesville, P.O. Box 100005** **Fringe Benefits/Jacksonville, P.O. Box 44008, Jax, FL 32231** Reset