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