

LIFE/DISABILITY UPDATE FORM

(OHSU UNIVERSITYFLEX BENEFITS PROGRAM)

This form replaces any prior enrollment form. Please fill out the update form completely.

Complete this form to make changes in your life/disability insurance coverage. Benefits election changes must be on account of and consistent with the qualified family status change, and must be requested and returned within 31 days of the qualified family status change. Refer to the OHSU UniversityFlex Selection and Eligibility Guides for more specific guidelines.

Employee Information		<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Qualified Family Status Change
Social Security No.		Date of Birth		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Last Name		First Name		Middle Initial	
Previous Name (If Name Change)			Work Phone	Home Phone	
Address			Department	Mail Code	
City	State	Zip	County		

1. Qualified Family Status Change (QFSC): Indicate your QFSC and provide the date when the status change occurred.

DATE OF STATUS CHANGE _____ **(Required)**

- Marriage
 Adoption
 Birth
 Divorce (Use final date)
 Death of dependent
 Other (be specific) _____

2. Indicate the change you are requesting. **NOTE: All coverages previously in effect will be continued unless you request a change.**

If adding Spouse/Partner Life Plan, indicate the name of the spouse/partner _____ **Date of Birth** _____

Plans	Current Coverage Check to continue▼	QFSC Benefit Change	Comment	OFFICE USE ONLY
Employee Life	<input checked="" type="checkbox"/> Continue coverage	<input type="checkbox"/> Enroll \$ _____ <input type="checkbox"/> Add \$ _____	Employee Life must be equal to or greater than Spouse/Partner Life	Code: Eff date:
Spouse/Partner Life	<input type="checkbox"/> Continue coverage	<input type="checkbox"/> Enroll \$ _____ <input type="checkbox"/> Cancel	Spouse/Partner Life must be equal to or less than Employee Life	Code: Eff date:
Dependent Life	<input type="checkbox"/> Continue coverage	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	First dependent child, at least \$25,000 of Employee Life	Code: Eff date:
Employee AD&D	<input type="checkbox"/> Continue coverage	<input type="checkbox"/> Enroll \$ _____	If QFSC adds the first dependent	Code: Eff date:
Dependent AD&D	<input type="checkbox"/> Continue coverage	<input type="checkbox"/> Enroll	If QFSC adds the first dependent	Code: Eff date:
Short Term Disability	<input checked="" type="checkbox"/> Continue coverage		No changes allowed	Code: Eff date:
Long Term Disability	<input checked="" type="checkbox"/> Continue coverage		No changes allowed	Code: Eff date:
				OHSU Approval:

3. Beneficiary Designation No change New beneficiary designation

Name of Beneficiary	Social Security#	Address	Relationship	Date of Birth

I understand the elections I have made are in effect, pending approval by Standard Insurance Company (if required) and so long as eligibility requirements are met, until I elect to change them subject to the provisions of each plan. Benefit costs will be taken out of my pay by payroll deduction. I have read the benefits materials and understand the limitations and qualifications of the OHSU benefits program.

EMPLOYEE SIGNATURE _____ DATE _____

Please return the completed form to the OHSU Human Resources Benefits Office, HR