Syracuse University
Human Resources

hrservic@syr.edu

Dependent Information to Add/Drop Benefits Coverage

Employee Name: _____ Date: _____

Signature: _____ SUID: _____

Please complete the requested information for each eligible dependent to be covered by, or removed from, your SU medical, dental, and/or dependent life insurance coverage(s). **This form must be submitted, together with your benefit enrollment forms to the Office of Human Resources, within 31 days after each dependent first becomes eligible for coverage (except to the extent otherwise provided by the applicable plan). If you have a dependent who no longer satisfies the applicable eligibility requirements for coverage, you must notify the Office of Human Resources within 31 days of the date such requirements are no longer satisfied.**

Answers in all fields below are required. If this form has missing or inaccurate data, it will be returned to you for completion or correction. Missing or inaccurate data could cause your benefit elections to be delayed and possibly denied. Additional copies of this form may be used if you have more than two dependents. Please sign and return this form to the Office of Human Resources via email to hrservic@syr.edu or fax to 443.1063 or mail to Skytop Office Bldg., Suite 101, Syracuse, NY 13244.

DEPENDENT 1

Full Name: _____
(Last, First, Middle Initial)

☐ Add ☐ Drop

Relationship: _____ Gender: ☐ Male ☐ Female

Birth Date: _____ Marriage Date: (if applicable) _____

Social Security Number: _____
(mandatory unless dependent is not eligible for a Social Security Number)

Full-time Student: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No

Medical/Prescription Drug: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Life Insurance: ☐ Add ☐ Drop

Address if different from employee: _____

DEPENDENT 2

Full Name: _____
(Last, First, Middle Initial)

☐ Add ☐ Drop

Relationship: _____ Gender: ☐ Male ☐ Female

Birth Date: _____ Marriage Date: (if applicable) _____

Social Security Number: _____
(mandatory unless dependent is not eligible for a Social Security Number)

Full-time Student: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No

Medical/Prescription Drug: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Life Insurance: ☐ Add ☐ Drop

Address if different from employee: _____

Return this form to:
HR Service Center
hrservic@syr.edu
Phone 315.443.4042 Fax 315.443.1063
Skytop Office Bldg., Suite 101, Syracuse, NY 13244