Syracuse University

Dependent Information to Add/Drop Benefits Coverage

Return this form to:
HR Shared Services
hrservice@syr.edu
Phone: 315.443.4042 **Fax:** 315.443.1063
621 Skytop Road, Suite 1001, Syracuse, NY 13244

Please complete the requested information for each eligible dependent to be covered by, or removed from, your SU health, dental, vision, 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.

Employee Information:

SUID * _____ **Employee Name *** _____

Employee Signature * _____ **Date *** _____

Dependent 1:

☐ **Add Dependent** ☐ **Drop Dependent**

Full Name (First, Middle, Last) * _____ **Social Security Number *** _____-_____-_____

Relationship * _____ **Birth Date *** _____ **Marriage Date (if applicable)** _____

Primary Personal Phone * _____ **Primary Personal Email *** _____

Address if different from employee * _____

Gender: * ☐ Man ☐ Woman

Disabled: * ☐ Yes ☐ No

Health Benefits: * ☐ Add ☐ Drop

Vision Benefits: * ☐ Add ☐ Drop

Dental Benefits: * ☐ Add ☐ Drop

Dependent Life Insurance: * ☐ Add ☐ Drop

Dependent 2:

☐ **Add Dependent** ☐ **Drop Dependent**

Full Name (First, Middle, Last) * _____

Social Security Number * _____-_____-_____

Relationship * _____

Birth Date * _____

Marriage Date (if applicable) _____

Primary Personal Phone * _____

Primary Personal Email * _____

Address if different from employee * _____

Gender: * ☐ Man ☐ Woman

Disabled: * ☐ Yes ☐ No

Health Benefits: * ☐ Add ☐ Drop

Vision Benefits: * ☐ Add ☐ Drop

Dental Benefits: * ☐ Add ☐ Drop

Dependent Life Insurance: * ☐ Add ☐ Drop

Dependent 3:

☐ **Add Dependent** ☐ **Drop Dependent**

Full Name (First, Middle, Last) * _____

Social Security Number * _____-_____-_____

Relationship * _____

Birth Date * _____

Marriage Date (if applicable) _____

Primary Personal Phone * _____

Primary Personal Email * _____

Address if different from employee * _____

Gender: * ☐ Man ☐ Woman

Disabled: * ☐ Yes ☐ No

Health Benefits: * ☐ Add ☐ Drop

Vision Benefits: * ☐ Add ☐ Drop

Dental Benefits: * ☐ Add ☐ Drop

Dependent Life Insurance: * ☐ Add ☐ Drop