



BENEFIT CHANGE REQUEST FOR FACULTY, PROFESSIONAL/SCIENTIFIC, MERIT EXEMPT STAFF

Employee Name (please print) _____ ID#: _____
(Use Social Security #, Employee ID# or University ID #)

- Complete this form and return to the University Benefits Office at 120 USB, Suite 40 (fax: 319-335-2776). If you have questions, call the University Benefits Office at 319-335-2676.
- You must make your new benefit selections online at the University Self-Service web site: <https://hris.uiowa.edu>.** You will be able to edit your benefit selections approximately 48 hours after the Benefits Office receives the form. (If the form is received within six (6) working days prior to the end of a month, the Self-Service site will not be available until the second working day of the following month.)
- Provide the following information:

I wish to modify my current benefit elections with The University of Iowa as a result of the event(s) below. Please check the appropriate item(s):

- | | | |
|--|--|---|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Dependent returning to school full time
Name of school _____ | <input type="checkbox"/> Change of work schedule/site for self/spouse/partner/dependent |
| <input type="checkbox"/> Birth/Adoption | <input type="checkbox"/> Dependent no longer eligible | <input type="checkbox"/> Change in daycare provider |
| <input type="checkbox"/> Death | <input type="checkbox"/> Unpaid leave of absence for self/spouse | <input type="checkbox"/> Change of employment for spouse/partner |
| <input type="checkbox"/> Divorce/termination of domestic partnership | <input type="checkbox"/> Domestic Partner Affidavit | |
| <input type="checkbox"/> Legal Separation | <input type="checkbox"/> Change of residence | |

Individual(s) involved in the above event:

Name: _____ Date event occurred: _____
 Name: _____ Date event occurred: _____

Changes will take effect the first day of the month after the event, except in the case of birth or adoption when the benefit change takes effect the first day of the month in which the event occurs.

- I understand that for this change to be effective it must be made **within 30 days of the date of the event (60 days for birth or adoption) and I must go to <https://hris.uiowa.edu> to enroll in benefits.** This request will be subject to any changes or limitations mandated by federal law concerning the affected agreement.

Under the penalties of perjury, I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct and complete.

Signature: _____ Date: _____

The University of Iowa requests the above information for the purpose of enrolling you in the Salary Reduction/Deduction Program for insurances and flexible spending accounts. Individuals outside the University employed by the companies who supply and administer the University benefits will have access to this information. No other persons outside of the University are routinely provided this information. Responses to all items are required. If you fail to provide the required information, the University may deny the respected benefit or complete the information to the best of its ability.

Office Use Only
Effective Date: _____