

# Post-Doctoral Associates

## Making Changes to Participant Benefits

**It is your responsibility to contact the Benefits Office to drop dependents within 30 days of loss of eligibility. Dropping after 30 days may result in ineligibility for refunds of overpayments.**

Any questions? Contact the University Human Resources, Service Center at 515-294-4800 or 877-477-7485 and ask to speak to a Benefits Consultant.

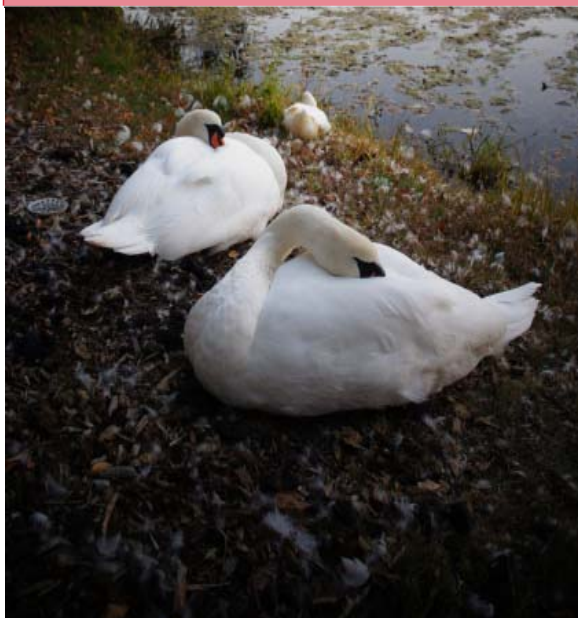


When enrolled in health insurance and dental insurance your benefit elections remain in effect until a change is made. You cannot make any changes until the next open change period **unless** you experience a qualified life event and the benefit change you request is consistent with the event.

Qualified events are defined by Section 125 of the Internal Revenue Code, based on individual circumstances and plan eligibility.

“Change in family status” is the Internal Revenue Service rule that allows you to adjust your benefit selections when unforeseen circumstances occur between change periods. Only specific events qualify as a change in family status.

For example: A marriage is a family status change that would allow you to change from single health and/or dental coverage to a different tier of health and/or dental coverage because acquiring a spouse is consistent with a gain in eligibility for health or dental coverage.



**It is your responsibility to contact the Benefits Office to drop dependents within 30 days of loss of eligibility. Dropping after 30 days may result in ineligibility for refunds of overpayments.**

Any questions? Contact the University Human Resources, Service Center at 515-294-4800 or 877-477-7485 and ask to speak to a Benefits Consultant.

**Click on the qualifying event to find answers to general questions about event:**

- **Birth or Adoption**
- **Spouse and/or Children Arriving in U.S.**
- **Legal Marital Status Change**
  - Marriage
  - Divorce/Annulment
- **Death of Participant**
  - Spouse/Partner
  - Dependent Child
- **Dependent's Status Change**
  - Becomes Full-Time Student
  - No Longer Eligible
  - Judgment/Decree/Court Order for Coverage
- **Employment Status**
  - You
    - Loss of Benefits Eligibility
    - Change in Scheduled Hours
      - Full-Time to Part-Time
      - Full-Time to Not Benefits Eligible
      - Not Benefit Eligible to Benefits Eligible
      - Rehired Less than 30 days after Termination of Employment
  - Spouse/Partner or Dependent
    - Spouse/Partner Terminates Employment
    - Spouse/Partner or Dependent Commences Employment
    - Change to Become Non-Eligible
    - Change to Become Eligible
- **Leave of Absence (including FMLA)**
  - Commencing Unpaid Leave
    - Excess of 30 Days (No FMLA)
    - Excess of 30 Days (FMLA)
  - Returning from Unpaid Leave
- **Entitlement to Medicare or Medicaid**
  - Becomes Entitled to Medicare or Medicaid
  - Spouse/Partner Loses Entitlement
- **Change in Residence**
  - Ineligible under Employer's Plan or for Current Benefits Option
  - Newly Eligible under Employer's Plan or for New Benefits Option
  - Ineligible under Spouse's/Partner's Current Benefits Option or Plan
  - Newly Eligible under Spouse's/Partner's Plan or for New Benefits Option

*This list may not apply to every benefit plan.*

## BIRTH OR ADOPTION

| Actions to Take  | Health Insurance  | Dental Insurance   |
|--|---|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 60 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"><li>• Need Proof of Adoption</li></ul> | <p>Allowed to enroll:</p> <ul style="list-style-type: none"><li>• Newly eligible dependent</li><li>• Spouse/partner</li><li>• Other dependents</li></ul> <p>Allowed to cancel coverage:</p> <ul style="list-style-type: none"><li>• If become covered by spouse's/partner's health plan</li></ul> | <p>Allowed to enroll:</p> <ul style="list-style-type: none"><li>• Newly eligible dependent</li><li>• Spouse/partner</li><li>• Other dependents</li></ul> |

## SPOUSE AND/OR CHILDREN ARRIVING IN U.S.

| Actions to Take   | Health Insurance  | Dental Insurance   |
|---|---|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 60 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"><li>• Passport(s)</li></ul> | <p>Allowed to enroll:</p> <ul style="list-style-type: none"><li>• Newly eligible dependent</li><li>• Spouse/partner</li><li>• Other dependents</li></ul> <p>Allowed to cancel coverage:</p> <ul style="list-style-type: none"><li>• If become covered by spouse's/partner's health plan</li></ul> | <p>Allowed to enroll:</p> <ul style="list-style-type: none"><li>• Newly eligible dependent</li><li>• Spouse/partner</li><li>• Other dependents</li></ul> |

## LEGAL MARITAL STATUS CHANGE MARRIAGE

| Actions to Take   | Health Insurance  | Dental Insurance  |
|---|---|---|
| <p><b>Forms:</b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b>Document Needed:</b></p> <ul style="list-style-type: none"> <li>Declaration of Relationship</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>Enroll in coverage</li> <li>Add eligible family members to existing health plan</li> <li>Cancel coverage if become covered by spouse's/partner's health plan</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>Enroll in coverage</li> <li>Add eligible family members to existing dental plan</li> <li>Cancel coverage if become covered by spouse's/partner's dental plan</li> </ul> |

## LEGAL MARITAL STATUS CHANGE DIVORCE/ANNULMENT

| Actions to Take  | Health Insurance  | Dental Insurance  |
|--|---|---|
| <p><b>Forms:</b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b>Document Needed:</b></p> <ul style="list-style-type: none"> <li>Divorce Decree or Court Document</li> </ul> | <p>Must remove:</p> <ul style="list-style-type: none"> <li>Former spouse/partner</li> <li>Former spouse's/partner's eligible family members from coverage</li> </ul> <p>Cannot remove:</p> <ul style="list-style-type: none"> <li>Other dependents from coverage unless they are added to former spouse's/partner's plan</li> </ul> <p>Allowed to:</p> <ul style="list-style-type: none"> <li>Enroll in coverage</li> <li>Add dependents if the event causes loss of coverage under former spouse's/partner's plan</li> </ul> | <p>Must remove:</p> <ul style="list-style-type: none"> <li>Former spouse/partner</li> <li>Former spouse's/partner's eligible family members from coverage</li> </ul> <p>Cannot remove:</p> <ul style="list-style-type: none"> <li>Other dependents from coverage unless they are added to former spouse's/partner's plan</li> </ul> <p>Allowed to:</p> <ul style="list-style-type: none"> <li>Add dependents to existing dental plan if the event causes loss of coverage under former spouse's/partner's plan</li> </ul> |

**DEATH OF PARTICIPANT  
SPOUSE'S/PARTNER'S DEATH**

| Actions to Take   | Health Insurance  | Dental Insurance  |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Death Certificate</li> </ul> | <p>Remove:</p> <ul style="list-style-type: none"> <li>• Spouse/partner from coverage</li> </ul> <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll in coverage</li> <li>• Add any dependent that loses coverage under deceased spouse's/partner's plan</li> </ul> | <p>Remove:</p> <ul style="list-style-type: none"> <li>• Spouse/partner from coverage</li> </ul> <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll in coverage</li> <li>• Add any dependent that loses coverage under deceased spouse's/partner's plan</li> </ul> |

**DEATH OF PARTICIPANT  
DEPENDENT'S DEATH**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"><li>• Death Certificate</li></ul> | <p>Remove:</p> <ul style="list-style-type: none"><li>• Deceased dependent from coverage</li></ul> | <p>Remove:</p> <ul style="list-style-type: none"><li>• Deceased dependent from coverage</li></ul> |

**DEPENDENT'S STATUS CHANGE  
BECOMES A FULL-TIME STUDENT**

| <b>Actions to Take</b>   | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|--|--|--|
| <p><b><u>Forms:</u></b><br/>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> | <p>Allowed to:</p> <ul style="list-style-type: none"><li>• Enroll the newly eligible dependent</li></ul> | <p>Allowed to:</p> <ul style="list-style-type: none"><li>• Enroll the newly eligible dependent</li></ul> |



**DEPENDENT'S STATUS CHANGE  
NO LONGER ELIGIBLE BECAUSE OF  
AGE, STUDENT STATUS OR MARITAL STATUS**

| <b>Actions to Take</b>  | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|---|--|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> | <p>Allowed to:</p> <ul style="list-style-type: none"><li>• Only cancel coverage for dependent that is no longer eligible</li></ul> | <p>Allowed to:</p> <ul style="list-style-type: none"><li>• Only cancel coverage for dependent that is no longer eligible</li></ul> |

**DEPENDENT'S STATUS CHANGE  
JUDGMENT, DECREE OR ORDER (INCLUDING QMCSO)  
RELATING TO HEALTH COVERAGE FOR CHILD**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Divorce Decree or Court Order</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Add dependent to existing plan if required under order</li> <li>• Cancel dependent if other parent provides coverage under order</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Add dependent to existing plan if required under order</li> <li>• Cancel dependent if other parent provides coverage under order</li> </ul> |

**EMPLOYMENT STATUS  
LOSS OF BENEFITS ELIGIBILITY**

| <b>Actions to Take</b>  | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|---|--|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> | <p>Coverage terminates:</p> <ul style="list-style-type: none"> <li>• At the end of the following month of last day worked</li> </ul> <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Pay for continued coverage through COBRA for up to 18 months, if not eligible for Medicare</li> </ul> <p><b><u><a href="#">Click Here for COBRA Information</a></u></b></p> | <p>Coverage terminates:</p> <ul style="list-style-type: none"> <li>• At the end of the following month of last day worked</li> </ul> <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Pay for continued coverage through COBRA for up to 18 months</li> </ul> <p><b><u><a href="#">Click Here for COBRA Information</a></u></b></p> |

**CHANGE IN SCHEDULED HOURS  
FULL-TIME TO PART-TIME:  
40 HOURS TO 20 HOURS PER WEEK**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> | <p>If enrolled, allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage</li> </ul> <p>If enrolled in family coverage, allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel eligible family members</li> </ul> <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Change health plan</li> </ul> | <p>If enrolled, allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage</li> </ul> <p>If enrolled in family coverage, allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel eligible family members</li> </ul> |

**CHANGE IN SCHEDULED HOURS  
FULL-TIME TO NOT BENEFITS ELIGIBLE:  
40 HOURS TO LESS THAN 20 HOURS PER WEEK**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> | <p>Coverage terminates:</p> <ul style="list-style-type: none"> <li>At the end of the following month of last day of full-time work</li> </ul> <p>Allowed to:</p> <ul style="list-style-type: none"> <li>Pay for continued coverage through COBRA for up to 18 months, if not eligible for Medicare</li> </ul> <p><b><u><a href="#">Click Here for COBRA Information</a></u></b></p> | <p>Coverage terminates:</p> <ul style="list-style-type: none"> <li>At the end of the following month of last day of full-time work</li> </ul> <p>Allowed to:</p> <ul style="list-style-type: none"> <li>Pay for continued coverage through COBRA for up to 18 months, if not eligible for Medicare</li> </ul> <p><b><u><a href="#">Click Here for COBRA Information</a></u></b></p> |

**CHANGE IN SCHEDULED HOURS  
NOT BENEFITS ELIGIBLE TO BENEFITS ELIGIBLE:  
LESS THAN 20 HOURS TO 40 HOURS PER WEEK**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> | <p>Allowed to enroll:</p> <ul style="list-style-type: none"><li>• You</li><li>• Eligible family members</li></ul> | <p>Allowed to enroll:</p> <ul style="list-style-type: none"><li>• You</li><li>• Eligible family members</li></ul> |

**CHANGE IN SCHEDULED HOURS  
REHIRED LESS THAN 30 DAYS AFTER  
TERMINATION OF EMPLOYMENT**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> | <p>Allowed to:</p> <ul style="list-style-type: none"><li>• Reinstate prior plan election</li><li>• Make a new selection similar to a new hire</li></ul> | <p>Allowed to:</p> <ul style="list-style-type: none"><li>• Reinstate prior plan election</li><li>• Make a new selection similar to a new hire</li></ul> |

**EMPLOYMENT STATUS  
SPOUSE/PARTNER TERMINATES EMPLOYMENT**

| <b>Actions to Take</b>  | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|---|--|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Certificate of Coverage</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll in coverage</li> <li>• Add eligible family members if they lost coverage under spouse's/partner's plan</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll in coverage</li> <li>• Add eligible family members if they lost coverage under spouse's/partner's plan</li> </ul> |



**EMPLOYMENT STATUS  
SPOUSE/PARTNER OR DEPENDENT COMMENCES EMPLOYMENT**

| <b>Actions to Take</b>  | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|---|--|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Certificate of Coverage</li> </ul> | <p>If become covered by spouse's/partner's health plan, allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage for you and/or eligible family members</li> </ul> | <p>If become covered by spouse's/partner's dental plan, allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage for you and/or eligible family members</li> </ul> |

**CHANGE IN EMPLOYMENT STATUS  
EVENT CAUSES SPOUSE/PARTNER TO CEASE TO BE ELIGIBLE  
FOR COVERAGE UNDER THEIR PLAN**

| <b>Actions to Take</b>  | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|---|--|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Certificate of Coverage</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll in coverage</li> <li>• Add eligible family members</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll in coverage</li> <li>• Add eligible family members</li> </ul> |

**CHANGE IN EMPLOYMENT STATUS  
EVENT CAUSES SPOUSE/PARTNER OR DEPENDENT TO GAIN  
ELIGIBILITY FOR COVERAGE UNDER THEIR PLAN**

| <b>Actions to Take</b>  | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|---|--|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Certificate of Coverage</li> </ul> | <p>If become covered by spouse's/partner's health plan, allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage for you and/or eligible family members</li> </ul> | <p>If become covered by spouse's/partner's dental plan, allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage for you and/or eligible family members</li> </ul> <p>Enrolled in comprehensive plan:</p> <ul style="list-style-type: none"> <li>• Must satisfy 3 year lock in period</li> </ul> |

**LEAVE OF ABSENCE  
COMMENCE UNPAID LEAVE IN EXCESS OF 30 DAYS (NO FMLA)**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Elect to continue coverage</li> <li>• Cancel coverage</li> <li>• Continue coverage:<br/>Billed for the total cost of any premiums due. Premiums are paid with after-tax dollars.</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Elect to continue coverage</li> <li>• Cancel coverage</li> <li>• Continue coverage:<br/>Billed for the total cost of any premiums due. Premiums are paid with after-tax dollars.</li> </ul> |

**LEAVE OF ABSENCE  
COMMENCE UNPAID FMLA LEAVE IN EXCESS OF 30 DAYS**

| <b>Actions to Take</b>  | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|---|--|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Change health plan</li> <li>• Cancel coverage</li> <li>• Continue coverage:<br/>Billed for any premiums due at the same cost sharing agreement as active employees. Premiums are paid with after-tax dollars.</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage</li> <li>• Continue coverage:<br/>Billed for any premiums due at the same cost sharing agreement as active employees. Premiums are paid with after-tax dollars.</li> </ul> |

**LEAVE OF ABSENCE  
RETURN FROM UNPAID LEAVE OR UNPAID  
FMLA IN EXCESS OF 30 DAYS**

| <b>Actions to Take</b>   | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|--|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Need Health Proof of Release to Return to Work</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Reinstate prior election</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Reinstate prior election</li> </ul> |

**BECOMES ENTITLED TO MEDICARE OR MEDICAID  
EMPLOYEE, SPOUSE/PARTNER OR DEPENDENT**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Copy of Medicare Card</li> </ul> | <p>Allowed to cancel:</p> <ul style="list-style-type: none"> <li>• Coverage for you and/or eligible family member entitled to Medicare or Medicaid</li> </ul> | <p>Allowed to cancel:</p> <ul style="list-style-type: none"> <li>• Coverage for you and/or eligible family member entitled to Medicaid</li> </ul> |

**LOSES ENTITLEMENT TO MEDICARE, MEDICAID, HAWK-I,  
ANY GROUP HEALTH COVERAGE SPONSORED BY A  
GOVERNMENTAL OR EDUCATIONAL INSTITUTION**

| <b>Actions to Take</b>  | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|---|--|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Documents Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Copy of Medicare Card</li> <li>• Proof of Loss of Coverage</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll the eligible family members that lost coverage</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll the eligible family members that lost coverage</li> </ul> |



**CHANGE IN RESIDENCE  
BECOMES INELIGIBLE UNDER EMPLOYER'S PLAN  
OR FOR CURRENT BENEFITS OPTION**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Certificate of Coverage</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage if other coverage is available</li> <li>• Change plans</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage if other coverage is available</li> </ul> |

**CHANGE IN RESIDENCE  
BECOMES NEWLY ELIGIBLE UNDER EMPLOYER'S PLAN  
OR FOR NEW BENEFITS OPTION**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Certificate of Coverage</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage if other coverage is available</li> <li>• Change plans</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage if other coverage is available</li> </ul> |

**CHANGE IN RESIDENCE  
BECOMES INELIGIBLE UNDER SPOUSE'S/PARTNER'S  
CURRENT BENEFITS OPTION OR PLAN**

| <b>Actions to Take</b>  | <b>Health Insurance</b>  | <b>Dental Insurance</b>  |
|---|--|--|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Certificate of Coverage</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll in coverage</li> <li>• Add eligible family members</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Enroll in coverage</li> <li>• Add eligible family members</li> </ul> |

**CHANGE IN RESIDENCE  
BECOMES NEWLY ELIGIBLE UNDER  
SPOUSE'S/PARTNER'S  
PLAN OR FOR NEW BENEFITS OPTION**

| <b>Actions to Take</b>  | <b>Health Insurance</b>   | <b>Dental Insurance</b>   |
|---|---|---|
| <p><b><u>Forms:</u></b></p> <p>Contact Benefits Office within 30 days at <a href="mailto:benefits@iastate.edu">benefits@iastate.edu</a></p> <p><b><u>Document Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Certificate of Coverage</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage if other coverage is available</li> </ul> | <p>Allowed to:</p> <ul style="list-style-type: none"> <li>• Cancel coverage if other coverage is available</li> </ul> |