UNIVERSITY OF ROCHESTER

2024 Benefits Program Qualifying Event Change Form

(Retiree) Please Print– Please Complete ALL Applicable Sections

Retiree Information

Name (Last, First, Initial):_____

Address:_____

_____

Gender (M/F):_____ Date of Birth (MM/DD/YYYY):_____

Retiree/Employee ID#:_____ Phone Number:_____

E-mail Address:_____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Retirement Date (Last Working Date): _____

Please Check Desired Action

Please complete with date of qualifying event

❑ I am requesting a change to my Health and/or Dental Plan elections due to a Qualifying Event*
Date of Qualifying Event:_____

❑ I am requesting a change to my spouse/domestic partner's Health Plan elections due to gaining/losing eligibility for Medicare/Medicaid.*
Date of Qualifying Event:_____

❑ I would like to ADD a dependent(s) to my Health and/or Dental Plan due to a Qualifying Event*
Date of Qualifying Event:_____

❑ I would like to REMOVE a dependent(s) from my Health and/or Dental Plan due to a Qualifying Event*
Date of Qualifying Event:_____

***NOTE: Completed forms must be received by the Office of Total Rewards within 30 days of a qualifying event.**
For Medicare Advantage Plan changes, forms must be completed prior to the effective date of coverage.

Please Return Forms

The Office of Total Rewards kindly requests that you email completed forms to **retireebenefits@ur.rochester.edu** OR through the mail at 60 Corporate Woods, Suite 310, P.O. Box 270453, Rochester, NY 14627

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