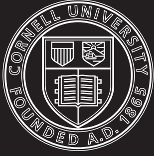

Cornell University
Benefit Services

Endowed Aetna Open Choice Health Care Program Enrollment Form

❑ Decedent spouse/same-sex partner
❑ Decedent child

❑ New enrollment
❑ Change

Employee Name (last, first, middle initial)		Social Security Number / /
Sex ( ) M ( ) F	Date of Birth / /	Employment Date / /
Home Address ______ City ______ State ______ Zip ______		Job Title ______
Department Name		Campus Address

Please select the coverage level you would like to enroll in below:

Effective Date: / /	Coverage: ( ) Individual ( ) Individual + Spouse/Same-sex Partner ( ) Individual + Child(ren) ( ) Individual + Spouse/Same-sex Partner + Child(ren)

If you wish to cover your spouse or same-sex partner, please complete the following:

Your Spouse or Same-sex Partner

Name of Spouse or Same-sex Partner		Spouse/Same-sex Partner Social Security Number / /
Date of Marriage/Partnership / /	Spouse/Same-sex Partner Date of Birth / /	Name of Spouse/Same-sex Partner Employer
If Cornell employment, name of department:		If Spouse/Same-sex partner employed, is health coverage available? ( ) yes ( ) no

If you wish to cover your eligible dependent child(ren) or your same-sex partner's child(ren), please complete the following:

Your Dependent Children/Same-sex Partner's Children

Name(s) of child(ren) (last, first, mi)	Date of Birth (mo/day/yr)	Relationship to you:	Is dependent disabled?	Social Security Number:

You are eligible for dual eligiblity (reduced individual + spouse/same-sex partner + child(ren) health premium) **if you meet the following requirements:**

1. You and your spouse/same-sex partner are both endowed employees.
2. You and your spouse/same-sex partner are both eligible for participation in the endowed health care plan.
3. You have dependent children covered by the plan.

If you are eligible for dual eligibility, please check here ( ) and have your spouse/same-sex partner sign below:

Endowed Spouse/Same-sex Partner Signature ______________________ Date ______________

I hereby declare that the information provided is correct, and that to the best of my knowledge and belief, I am eligible for insurance under the terms of Cornell University's health care program for endowed employees. I hereby request the insurance thereunder to which I am entitled or to which I may become entitled, and authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance.

Signature ______________________ **Date** ______________

10/07