ADELPHI UNIVERSITY
HEALTH INSURANCE ELECTION FORM

Please print your name and social security number below and check one of the options that is appropriate for your needs.

Print Name: _____

Social Security: _____

Choose One:

_____ PPO High Option
_____ PPO Standard Option
_____ HIP
_____ Waive Health Insurance Coverage

If electing family medical coverage under one of the Adelphi University's medical options, please sign below if all eligible dependents live with you.

It is the employee's responsibility to notify the Office of Human Resources if any eligible dependents change where they live. Also, Adelphi must be notified of any change in family status within 60 days after the event occurs.

_____ _____
Signature Date

If all eligible dependents do not live with you, please give the address for all eligible dependents.

_____

_____
Name: Relationship

_____
Address:

_____
Name: Relationship

_____
Address:

Signature: _____ Date: _____

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