

UNIVERSITY OF ROCHESTER Dependent Information Change Request Form

Please Print Clearly

Employee Information:

Name: _____

Employee ID#: _____ **Phone Number:** _____

E-Mail: _____

Dependent Information:

Directions: **Complete ALL information for any dependent you wish to update**

| Name | Relationship | Gender | Date-of-Birth | Social Security # (required field for all dependents*) |
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Signature:

Date:

* The Affordable Care Act requires all insurers and self-insured employer groups (UR) to report to the IRS the social security numbers (SSN) for each individual (employees and dependents) to whom the group provides minimum essential health care coverage (MEC) intended primarily to support the IRS' enforcement of the individual mandate. Please provide the SSN for each dependent to be enrolled under your University Health Care Plan.