Cornell University Division of Human Resources

Weill Cornell Medicine PPO Health Care Program Enrollment Form

❒Decedent spouse/domestic 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		
Campus Address	Telephone	Email

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

Effective date: / /	Coverage: ( ) Individual ( ) Individual + Spouse/Domestic Partner ( ) Individual + Child(ren) ( ) Individual + Spouse/Domestic Partner + Child(ren)

If you wish to cover your spouse or domestic partner, please check spouse ❒ or domestic partner ❒ and complete the following:

Name of Spouse or Domestic Partner		Spouse/Domestic Partner Social Security Number / /
Date of Marriage/Partnership / /	Spouse/Domestic Partner Date of Birth / /	Name of Spouse/Domestic Partner Employer
Sex ( ) M ( ) F	If employed by Cornell, name of department:	

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

Name(s) of child(ren) (last, first, mi)	Date of Birth (mo/day/yr)	Relationship to you:	Male/Female M/F	Social Security Number:

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

1. You and your spouse/domestic partner are both endowed employees.
2. You and your spouse/domestic 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/domestic partner sign below:

Endowed Spouse/Domestic 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. I authorize and understand that health insurance premiums will be retroactive to the eligibility date or qualifying event date. This means that double deductions will be taken from my paycheck if back premiums are owed. I also agree to review the imputed income information if I am covering my same-sex spouse or domestic partner at the following link: https://hr.cornell.edu/benefits-pay/benefits-enrollment/marriage-or-domestic-partnership

Signature _____ **Date** _____