ENROLLMENT FORM FOR GRADUATE STUDENT EMPLOYEES/FELLOWS AND THEIR DEPENDENTS

☐ NEW ☐ RE-APPOINTED ☐ ADD DEPENDENT ☐ DELETE DEPENDENT ☐ TERMINATE ☐ ADDRESS CHANGE ☐ CARD REQUEST

LAST NAME:	FIRST NAME:	EE #
Chauhan	Raghav Singh	SCHOOL ID # 50486848

MAILING ADDRESS: 32 Merrimac Street **CITY:** Buffalo **STATE:** New York **ZIP:** 14214

DATE OF BIRTH	SEX CODE	MARITAL CODE
_____/_____/_____	M ☐ F ☐	SINGLE ☐ MARRIED ☐ → MARRIAGE DATE ___/____/_____

HOME PHONE #	WORK PHONE#	CELL PHONE#	Have you been enrolled in the TA/GA health insurance plan within the last 28 days? If yes check box ☐
716-936-4265	716-936-4265	716-936-4265	

DEPARTMENT NAME & ZIP	EMAIL ADDRESS:	VISA TYPE : F1 ☐ J1 ☐
	raghavsi@buffalo.edu	

ENTER REQUEST BELOW (CHECK ONE BOX)

☐ I DECLINE COVERAGE ☐ INDIVIDUAL ☐ INDIVIDUAL +1 ☐ INDIVIDUAL +2 OR MORE

REASON FOR CHANGE

☐ CHANGE TO FAMILY

☐ CHANGE TO INDIVIDUAL

☐ ARRIVAL OF ELIGIBLE DEPENDENT IN UNITED STATES

☐ REQUEST COVERAGE FOR DEPENDENTS

☐ REQUEST FOR DOMESTIC PARTNER HEALTH INSURANCE

☐ MARRIAGE _____

☐ NEW BORN _____

☐ SPOUSE COVERAGE ENDED_____

☐ OTHER_____

DEPENDENT INFORMATION

LAST NAME	FIRST NAME	SEX	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY#
		M F	____/____/____		
		M F	____/____/____		
		M F	____/____/____		
		M F	____/____/____		

EMPLOYEE SIGNATURE: **DATE:** 09/25/2023

I hereby authorize deductions from my salary of the amount required, if any, for the insurance indicated. This authorization will be in effect until revoked in writing. GSEHP insurance deduction is paid on a pre-tax basis unless a waiver form is submitted. (See *Graduate Student Benefits Handbook* for pre-tax medical insurance deduction information.)

EFFECTIVE DATE OF COVERAGE OR CHANGE:	COMMENTS:

PROCESSOR: ORACLE ☐_____ ☐ _____ SCANNING ☐ _____