FAES
FOUNDATION FOR ADVANCED EDUCATION IN THE SCIENCES

Fellow Change Form

Medical, Dental and Vision

First Name:	MI:	Last Name:
Date of Birth: (MM-DD-YYYY)		

Institute: (Please check one)

NCATS	NIA	NIDA	NIMH	CC
NCCIH	NIAAA	NIDCD	NIMHD	CIT
NCI	NIAID	NIDCR	NINDS	CSR
NEI	NIAMS	NIDDK	NINR	FIC
NHGRI	NIBIB	NIEHS	NLM	OD
NHLBI	NICHD	NIGMS		

Department:

Fellow

Change in Current Coverage Level:

FROM:		TO:
	Individual	
	Family	

Qualifying Event Date:_____

FAES USE:
Request Effective Date:_____

Qualifying Event:

Marriage
Loss of Coverage
Newborn/Adoption
Other_____

DEPENDENTS

Name: (Last, First, MI)	Relationship to Subscriber:	Social Security #:	Birth Date (MM-DD-YYYY)	Sex Assigned at Birth*: M	F	Same Address as Subscriber
	Spouse					Y N
	Dependent					Y N
	Dependent					Y N
	Dependent					Y N

Spouse or Dependent's Address: (if address is different from subscriber)

CHANGE OF ADDRESS:

FROM:	TO:

CHANGE OF NAME:

FROM:	TO:

If your spouse works at the NIH, please list their full name here:_____

**Sex Assigned at Birth might be different from current gender identity.*
FAILURE TO SELECT A SEX MAY RESULT IN CLAIM DENIALS.

Employee Signature:	Date
FAES Representative Signature:	Date

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