

YOUNGSTOWN STATE UNIVERSITY  
Same-Sex Domestic Partner  
Health Election Form

**SECTION I: Personal Information**

Employee's Name _____	Employee ID _____
Home Address _____	
Email Address _____	Daytime Phone: _____

**SECTION II: Reason for Completing Form**

<input type="checkbox"/> Same-Sex Domestic Partner Enrollment (form due _____ )	<input type="checkbox"/> Termination of SSDP	<input type="checkbox"/> Loss of coverage - SSDP
<input type="checkbox"/> New hire	<input type="checkbox"/> Birth of a child	<input type="checkbox"/> Loss of coverage - child
<input type="checkbox"/> Re-hire	<input type="checkbox"/> Adoption/legal guardianship	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Returning retiree	<input type="checkbox"/> Change in dependent eligibility	_____
<input type="checkbox"/> Met Affidavit of SSDP requirements	<input type="checkbox"/> Change in mailing address	_____
	<input type="checkbox"/> Obtained new coverage	

**SECTION III: Health Coverage Selection**

<p>1. Medical Coverage</p> <p>___ Elect/change coverage</p> <p>___ Waive medical coverage</p> <p>Select medical plan desired:</p> <p>___ Anthem (HMP)</p> <p>___ Medical Mutual (Super Med Classic)</p> <p>___ Super Med Select (POS)</p>	<p>2. Dental Coverage</p> <p>___ Elect/change coverage</p> <p>___ Waive dental coverage</p> <hr/> <p>3. Vision Coverage</p> <p>___ Elect/change coverage</p> <p>___ Waive vision coverage</p>	<p>4. Prescription</p> <p>___ Elect/change coverage</p> <p>___ Waive RX coverage</p>
---	---	--

**SECTION IV: Name of Same-Sex Domestic Partner and Same-Sex Domestic Partner's Eligible Dependents**

Relationship to Employee	Name	Birth Date (M/D/Y)	Gender M/F	Social Security #	Choose coverage for each eligible person:			
					Medical	Dental	Vision	Prescription
Employee					__ Y __ N	__ Y __ N	__ Y __ N	__ Y __ N
SSDP					__ Y __ N	__ Y __ N	__ Y __ N	__ Y __ N
SSDP Dependent					__ Y __ N	__ Y __ N	__ Y __ N	__ Y __ N
SSDP Dependent					__ Y __ N	__ Y __ N	__ Y __ N	__ Y __ N
SSDP Dependent					__ Y __ N	__ Y __ N	__ Y __ N	__ Y __ N

**SECTION V: Authorization**

I hereby certify that the above named person(s) and I meet all of the eligibility requirements as "Same-Sex Domestic Partners" and dependents under Youngstown State University's policy and as set forth in the *Affidavit of Domestic Partnership*.  
I understand that: 1) falsely certifying eligibility or failing to inform Youngstown State University of any changes that would affect eligibility could result in disciplinary action, including termination of employment; 2) Youngstown State University may ask me to provide evidence that the eligibility requirements are being met; 3) I will be required to pay 10% of the family coverage premium; and 4) the value of the additional premium benefit will be considered taxable income to me.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date