INDIANA UNIVERSITY

Anthem U65 PPO HDHP

ADDRESS CHANGE OR COVERAGE TERMINATION FORM

Submit this form only if:

- you need to change your mailing address; or
- you wish to cancel your IU-sponsored medical coverage; or
- you wish to drop medical coverage for your dependents.

Complete only the sections that apply.

You can disregard this form if:

- your address remains the same; and
- you wish to continue enrollment in IU-sponsored medical coverage.

PARTICIPANT INFORMATION

Last Name:	First Name:	Middle Initial:
Anthem ID Number:		

ADDRESS CHANGE

Complete this section only if you have an address change to report.

Street:		
City:	State:	Zip:
Phone:	Email:	
Signature:		Date:

CANCEL COVERAGE

Complete this section only if you wish to cancel coverage for yourself and/or your dependent(s). Check all options that apply.

☐ Cancel my IU-sponsored medical plan coverage effective December 31, 2024.

☐ Drop the following dependents from my IU-sponsored medical plan coverage effective December 31, 2024:

Dependent Name	Relationship to You	Date of Birth (mm/dd/yyyy)

Signature:	Date:

Return to askhr@iu.edu; or mail to IU Human Resources, ATTN: Retiree Specialist, 2709 E 10th Street, Suite 321, Bloomington, IN 47408.