

PERSONAL DATA SHEET

New Hire Change

Full-time Part-time

Prefix:	*Last Name:	*First Name:	*Middle Name:
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***List legal name as it appears on the social security card.**

HOME ADDRESS:

Street Line 1:	Street Line 2:
City, State, Zip:	County:
Home Phone:	Cell Phone:
Personal Email Address:	

LOCAL ADDRESS:

Street Line 1:	Street Line 2:
City, State, Zip:	County:

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Social Security Number:	Citizenship: <input type="checkbox"/> US Citizen <input type="checkbox"/> Non-Resident Alien <input type="checkbox"/> Permanent Resident
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Marital Status:	Please complete both boxes.		
<input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Race: Check all that apply <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	

PRIMARY EMERGENCY CONTACT	SECONDARY EMERGENCY CONTACT
Name:	Name:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Relationship:	Relationship:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:

Home Department:	Date Employed:	Date I-9 Form Completed:	Expiration Date:
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FOR INTERNATIONAL FACULTY, STAFF, STUDENTS:

Visa Type:	Visa Number:	Nation of Issue:
Passport Number:	Nation of Issuer:	Expiration Date:
Status: <input type="checkbox"/> F-1 <input type="checkbox"/> H1-B <input type="checkbox"/> J-1	Expiration Date:	Duration of Stay:
		Alien Registration Number:

*****FULL TIME EMPLOYEES SEE REVERSE*****

For Full-Time Employees Only:

DEPENDENT DATA: Legal Spouse and Dependent Child(ren) Eligibility Requirements – refer to complete definitions in official plan documents located at www.duq.edu/benefits.

- **Spouse** means the legal spouse under the laws of the state where the marriage was performed provided that a state-issued marriage certificate is obtained. *A copy of a certified marriage certificate will be required to obtain University sponsored benefits.* Marriage certificates may be obtained from the county courthouse that issued the original certificate. Pennsylvania Health Statistics and Vital Records are available at www.health.state.pa.us.
- **Dependent Child(ren)** are defined as any child of the Employee who is under age twenty-six (26). *A copy of the front and back of the child's certified birth certificate will be required to obtain University sponsored benefits.* Pennsylvania Health Statistics and Vital Records are available at www.health.state.pa.us. Your child(ren) include:
 - **Biological child**
 - **Stepchild**
 - **Legally adopted child** who is under age 18 at the time of the adoption, or child placed in anticipation for adoption who lives with you (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced). Employees will be required to provide a copy of the court order specifying legal custody or a copy of the certified adoption papers, or a copy of the court order specifying legal custody, and a certified copy of the front and back of the revised birth certificate issued from the Department of Vital Statistics.
 - **Child who qualifies for benefits under a Qualified Medical Child Support Order.** Employees will be required to provide a copy of the Support Order.
 - **Child who is disabled (mentally or physically incapable of self-support)** prior to age 26, was enrolled in group medical coverage and completes certification of disability.
 - **Child for whom you have legal guardianship under a court order and who lives with you.** Employees will be required to provide a copy of the court order. Due to the expiration of legal guardianship at the age of 18, the University will permit the previously documented legal guardianship to be used as proof of eligibility purposes. The employee must be able to document legal guardianship for five continuous, consecutive years prior to the child turning 18 (i.e., between the ages of 13 to 18) to be considered eligible. Special consideration may be provided if an unusual circumstance resulted in a break in the guardianship between the ages of 13 to 18 if the employee can prove the guardianship was entered into for a minimum of ten years.
- **Tuition Remission Benefits** Dependents are eligible for tuition remission benefits *through the age of 25 only if they are dependent chiefly on employee* for support and maintenance, are not employed full time, and are enrolled on a full-time basis (as determined by the school). School vacation periods during any calendar year that interrupt but do not terminate a continuous course of study will be considered school attendance for those individuals who attend school on a full time basis. Verification of full time status is audited each semester and upon request via a signed statement from the registrar. The University reserves the right to verify dependent status by requesting previous year's tax return, with financial information redacted, indicating the dependent status of the student.

Name (First, Middle, Last)	Social Security Number	Birthdate	Sex	Child is my	Child is	Medicare Eligible?
Spouse		Month/Day/Year	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 1			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Medical Support Order <input type="checkbox"/> Legal Guardianship	<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 2			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Medical Support Order <input type="checkbox"/> Legal Guardianship	<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 3			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Medical Support Order <input type="checkbox"/> Legal Guardianship	<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 4			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Medical Support Order <input type="checkbox"/> Legal Guardianship	<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 5			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Medical Support Order <input type="checkbox"/> Legal Guardianship	<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No

You must present documentation as listed above to the Benefits Office within 30 days from the benefits effective date.

EMPLOYEE SIGNATURE: I certify that the information above is true and correct. I understand that it is my responsibility to complete a Qualified Life Event Form within 30 days of a change in dependent status. I understand any employee concealing, deceiving, or misrepresenting information will be subject to disciplinary action up to and including termination of benefits, termination of employment, and/or prosecution. Any claims paid for ineligible dependents will require restitution.

Signature: _____ Date: _____ Print Name: _____