



# 2010 POSTDOCTORAL FELLOW BENEFITS ENROLLMENT

FOR FULL-TIME POSTDOCTORAL CLINICAL FELLOWS AND POSTDOCTORAL RESEARCH FELLOWS NOT RECEIVING SALARY

## TIME-SENSITIVE: COMPLETE BY 11/20/2009 TO MAKE CHANGES FOR 2010 PLAN YEAR

### PERSONAL INFORMATION (to be completed by the postdoctoral fellow)

Name: \_\_\_\_\_ UNI/Employee ID: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: ( ) - \_\_\_\_\_

Department: \_\_\_\_\_ E-mail: \_\_\_\_\_

### MEDICAL AND DENTAL PLANS (to be completed by the postdoctoral fellow)

Please check off one of the following medical coverage options. For plan details, consult Benefits in Brief for Officers, available on the web at [www.hr.columbia.edu/hr/benefits-page-section.html](http://www.hr.columbia.edu/hr/benefits-page-section.html).

**Important Notes:** HIP HMO requires a special enrollment form that is available at [www.hr.columbia.edu/hr/](http://www.hr.columbia.edu/hr/).

CIGNA POS plan requires a Primary Care Provider (PCP) Selection form, also available at [www.hr.columbia.edu/hr/](http://www.hr.columbia.edu/hr/).

\*Relationship codes:

PDF=Post-Doctoral Fellow / SP = Spouse / DP = Same-Sex Domestic Partner

<b>MEDICAL PLANS</b>	Individual	PDF & SP/DP	PDF & Child(ren)	Family Plan
CIGNA 100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CIGNA 90	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UHC 100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UHC 90	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aetna Point-of-Service II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CIGNA Modified Indemnity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIP HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aetna HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>DENTAL PLAN</b>				
Aetna Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### DEPENDENT INFORMATION (to be completed by the postdoctoral fellow)

Indicate the dependent(s) you wish to cover under your medical plan. Please know that you must be prepared to provide proof of each dependent's eligibility if you are selected for audit at any time. SOCIAL SECURITY NUMBERS ARE REQUIRED!

Dependent #1 Name: \_\_\_\_\_ SSN (required!) \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dependent #2 Name: \_\_\_\_\_ SSN (required!) \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dependent #3 Name: \_\_\_\_\_ SSN (required!) \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Relationship codes: SP = Spouse / DP = Same-Sex Domestic Partner / SO = Son / DA = Daughter / LG = Legal Guardian



P.D. Fellow Signature \_\_\_\_\_ Date \_\_\_\_\_

**DEPARTMENT INFORMATION (TO BE COMPLETED BY THE DEPARTMENTAL ADMINISTRATOR)**

**I. PAYMENT OPTIONS (CHECK ONE OF THE FOLLOWING THREE OPTIONS):**

Department pays full cost (*IDI in advance*)  P.D. fellow pays full cost (*monthly premiums*)

Department pays part of the cost (*IDI in advance*) & postdoctoral fellow pays part (*monthly premiums*)

Department portion: \$ \_\_\_\_\_ Postdoctoral fellow portion: \$ \_\_\_\_\_

**II. POSTDOCTORAL FELLOW'S APPOINTMENT EFFECTIVE DATE:** \_\_\_\_\_

Dept. Admin. Signature \_\_\_\_\_ Date \_\_\_\_\_

**Return this Form to your Departmental Administrator by November 20,  
2009**