COLUMBIA UNIVERSITY HUMAN RESOURCES

2011 POSTDOCTORAL FELLOW BENEFITS ENROLLMENT

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

IMPORTANT: You must submit your completed form within 31 days of your hire date to receive benefits.

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*.
Also please visit "Postdoctoral Fellows: Medical Benefits" at: http://hr.columbia.edu/benefits/postdocs
Important Notes: HIP HMO requires a special **enrollment form** that is available at *www.hr.columbia.edu/hr/*.
CIGNA POS plan requires a **Primary Care Provider (PCP) Selection form**, also available at *www.hr.columbia.edu/hr/*.
**Relationship codes:*
PDF=Post-Doctoral Fellow / SP = Spouse / DP = Same-Sex Domestic Partner

MEDICAL PLANS	**Individual**	**PDF & SP/DP**	**PDF & Child(ren)**	**Family Plan**
CIGNA 100	☐	☐	☐	☐
CIGNA 90	☐	☐	☐	☐
UHC 100	☐	☐	☐	☐
UHC 90	☐	☐	☐	☐
Aetna Point-of-Service II	☐	☐	☐	☐
CIGNA Modified Indemnity	☐	☐	☐	☐
HIP HMO	☐	☐	☐	☐
Aetna HMO	☐	☐	☐	☐
DENTAL PLAN				
Aetna Dental	☐	☐	☐	☐

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**_____

PLEASE NOTE: INTERNAL REVENUE CODE SECTIONS 104 AND 105 REQUIRE THAT EMPLOYER CONTRIBUTIONS MADE BY YOUR DEPARTMENT OR YOUR GRANT FOR MEDICAL AND/OR DENTAL COVERAGE ARE INCLUDED AS TAXABLE INCOME FOR YOU. IMPUTED INCOME MEANS YOU PAY TAXES ON THE COST OR VALUE OF THE BENEFITS. IMPUTED INCOME IS REPORTED ANNUALLY ON YOUR W-2 OR 1099.

Return this Form to your Departmental Administrator within 31 days of your Date of Hire

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)*

Post doc fellows are subject to imputed income for any departmental contributions for medical and/or dental coverage.

*Department portion: $*_____ *Postdoctoral fellow portion: $*_____

II. POSTDOCTORAL FELLOW'S APPOINTMENT EFFECTIVE DATE: _____

Dept. Admin. Signature_____ **Date** _____

Departmental Administrators*: Please return this completed Form and the Interdepartmental Invoice (IDI) to Shawn Hayes, Benefits Specialist, at sh2276@columbia.edu at the Columbia University Benefits Service Center. If you have any questions, please call 212-851-7000.