

UNIVERSITY OF MASSACHUSETTS, Amherst
2009-2010 POSTDOCTORAL/RESEARCH FELLOW INSURANCE PLAN ENROLLMENT FORM
(Please type/print clearly)

Date: _____ Employee ID# or Campus ID# _____

Post Doc/Fellow Name: _____
Last First Initial

ID card Mailing Address _____
Street or P.O. Box City State/ Zip

Male _____ Female _____ Date of Birth ____/____/____ Email Address _____
MM DD YY

- **2009-2010 Rates:** (Please note that the Spouse and Child(ren) rates indicated below do not include the Post Doc/Fellow Rate.)

	ANNUAL TERM PREMIUM	MONTHLY PREMIUM
Post Doc/Fellow Only	\$2652	\$221
Spouse Only	\$6600	\$550
Child(ren) only*	\$4752	\$396

*rate is for one or more children.

- **Individuals to be enrolled** (aside from Post Doc/Fellow listed above):

	Last Name	First Name	Date of Birth	Gender
Spouse				
Child				
Child				
Child				

By signing below the Post Doc/Fellow acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form. 2) Rates are not prorated. 3) He/She meets the eligibility requirements for this coverage as described in the brochure. 4) If it is later determined that the Post Doc/Fellow is not eligible, the premium will be refunded. 5) A Dependent cannot be insured under this Plan if the Insured Post Doc/Fellow loses eligibility. 6) The premium is not refundable, except as noted above. 7) The Post Doc/Fellow is responsible for timely renewal payment.

I wish to enroll in the University of Massachusetts Amherst Postdoctoral/Research Fellow Insurance Plan. I have read the Post Doc/Fellow insurance brochure and understand the terms, conditions and limitations of coverage.

SIGNATURE OF POST DOC/FELLOW: _____ **DATE** _____

FOR FUNDING DEPARTMENT USE:

Department Contact _____ Email: _____ Phone: _____

Department _____ PO#:

Speed Type: _____ Project/Grant#: _____

Premium Calculation:
 Total Monthly Premium (Fellow): **\$221** x Number of Months _____ = Total Premium _____
 Total Monthly Premium (Spouse): **\$550** x Number of Months _____ = Total Premium _____
 Total Monthly Premium (Child): **\$396** x Number of Months _____ = Total Premium _____

Effective date of Fellow Appointment: _____

Effective dates of Policy: _____ To _____

PI SIGNATURE: _____ Date: _____