

**UNIVERSITY OF MASSACHUSETTS AMHERST  
2007-08 POSTDOCTORAL FELLOW INSURANCE PLAN ENROLLMENT FORM**

(Please Print)

Date: \_\_\_\_\_ Employee ID# \_\_\_\_\_ Campus ID# \_\_\_\_\_

Postdoctoral Fellow

Name \_\_\_\_\_

Last First Initial

ID Card Mailing Address \_\_\_\_\_

Street or P.O. Box City State Zip Code

Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Email Address \_\_\_\_\_

M D Y

I wish to enroll in the University of Massachusetts Amherst Postdoctoral Fellow Insurance Plan. I have read the Postdoctoral Fellow insurance brochure and understand the terms, conditions and limitations of coverage. It is the Post Doctoral Fellow's responsibility for timely renewal payment. By signing below, the Post Doctoral 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 other than as listed on this enrollment form. 3) He/She meets the eligibility requirements for this coverage as described in the brochure. 4) If it is later determined that the Post Doctoral Fellow is not eligible, the premium will be refunded. 5) A Dependent cannot be insured under this Plan if the Insured Post Doctoral Fellow loses eligibility under the Post Doctoral Fellow Medical Insurance Plan. 6) Other than for eligibility reasons, the premium is not refundable. Please note that the Spouse and Child(ren) rates indicated below do not include the Postdoctoral Fellow Rate. I wish to apply for the following classifications of coverage:

	ANNUAL TERM PREMIUM 09/01/07 – 08/31/08	OR	MONTHLY PREMIUM
Postdoctoral Fellow Only	\$2,184.00		\$182.00
Spouse Only	\$5,448.00		\$454.00
Child(ren) Only	\$3,924.00		\$327.00

	Last Name	First Name	MI	Date of Birth/Sex
Spouse:	_____	_____	_____	_____
Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____

SIGNATURE OF POSTDOCTORAL FELLOW: \_\_\_\_\_ DATE \_\_\_\_\_

**FOR FUNDING DEPARTMENT USE**

Department Contact: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Department: \_\_\_\_\_ P.O. # \_\_\_\_\_

Speed Type: \_\_\_\_\_ Project/Grant#: \_\_\_\_\_

**Premium Calculation:**

Total Monthly Premium (PostDoc): \$182.00 x Number of Months \_\_\_\_\_ = Total Premium \_\_\_\_\_

Total Monthly Premium (Spouse): \$454.00 x Number of Months \_\_\_\_\_ = Total Premium \_\_\_\_\_

Total Monthly Premium (Child): \$327.00 x Number of Months \_\_\_\_\_ = Total Premium \_\_\_\_\_

Effective date of Postdoctoral Appointment: \_\_\_\_\_

Effective dates of Policy: \_\_\_\_\_

PI Authorizing Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SEND OR FAX FORM TO: BEV STRAKOSE, RESEARCH AFFAIRS  
RESEARCH ADMINISTRATION BUILDING – FAX: 7-1728