UNIVERSITY OF MASSACHUSETTS
2008-09 POSTDOCTORAL/RESEARCH FELLOW INSURANCE PLAN ENROLLMENT FORM

PLEASE TYPE/PRINT CLEARLY

Date: _____ Employee ID# or Campus ID# _____

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_____
MM DD YY

I wish to enroll in the University of Massachusetts Amherst Postdoctoral/Research Fellow Insurance Plan. I have read the Fellow insurance brochure and understand the terms, conditions and limitations of coverage. It is the Fellow's responsibility for timely renewal payment. By signing below, the 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 Fellow is not eligible, the premium will be refunded. 5) A Dependent cannot be insured under this Plan if the Insured Fellow loses eligibility under the Fellow Medical Insurance Plan. 6) Other than for eligibility reasons, the premium is not refundable. Please note that the Spouse and Children) rates indicated below do not include the Fellow Rate. I wish to apply for the following classifications of coverage:

	ANNUAL TERM PREMIUM	**OR**	**MONTHLY PREMIUM**
Fellow Only	**$2,460.00**		**$205.00**
Spouse Only	**$6,132.00**		**$511.00**
Child(ren) (no extra cost for other children)	**$4,416.00**		**$368.00**

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

SIGNATURE OF FELLOW: _____ DATE_____

FOR FUNDING DEPARTMENT USE

Department Contact _____Email:_____ Phone: _____

Department _____ PO# _____

Speed Type: _____ Project/Grant#: _____

Premium Calculation:
Total Monthly Premium (Fellow): $205.00 x Number of Months _____ = Total Premium _____
Total Monthly Premium (Spouse): $511.00 x Number of Months _____ = Total Premium _____
Total Monthly Premium (Child): $368.00 x Number of Months _____ = Total Premium _____

Effective date of Fellow Appointment: _____

Effective dates of Policy: _____

PI Authorizing Signature: _____ Date: _____

FAX FORM TO: BEV STRAKOSE, RESEARCH AFFAIRS – 7-1728