

**UNIVERSITY OF MASSACHUSETTS, Amherst
2011-2012 POSTDOCTORAL INSURANCE PLAN ENROLLMENT FORM**

Date: _____ Employee ID# _____

Post Doc 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

- **2011-2012 Rates:** (Please note that the Spouse and Child(ren) rates indicated below do not include the Post Doc Rate.)

	ANNUAL TERM PREMIUM	MONTHLY PREMIUM
Post Doc Only	\$3348	\$279
Spouse	\$8340	\$695
Child(ren)*	\$6012	\$501

*rate is for one or more children

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

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

By signing below the Post Doc 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 is not eligible, the premium will be refunded. 5) A Dependent cannot be insured under this Plan if the Insured Post Doc loses eligibility. 6) The premium is not refundable, except as noted above. 7) The Post Doc is responsible for timely renewal payment.

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

SIGNATURE OF POST DOC: _____ DATE _____

FOR FUNDING DEPARTMENT USE:

Department Contact _____ Email: _____ Phone: _____

Department _____

PO#: _____

Premium Calculation:

Total Monthly Premium (Post Doc): **\$279** x Number of Months _____ = Total Premium _____

Total Monthly Premium (Spouse): **\$695** x Number of Months _____ = Total Premium _____

Total Monthly Premium (all Children): **\$501** x Number of Months _____ = Total Premium _____

Effective date of Post Doc Appointment: _____

Effective dates of Insurance Policy: _____ To _____

PI SIGNATURE: _____ Date: _____

FAX FORM TO: Melinda LeLacheur, Research Affairs - 7-1728