University of Massachusetts Amherst

Office of Human Resources

PostDoctoral Health Insurance Plan
Premium Payment Agreement Form

Name: _____ HR EmplID: _____

E-Mail Address: _____ Tel. Phone #: _____

☐ I am a PostDoctoral employee of the University of Massachusetts Amherst thus:

1. I hereby authorize the University of Massachusetts to withhold all employee contributions consistent with my health insurance enrollment on a pre-tax basis through payroll deduction.

2. Employee contributions will not be withheld if I have insufficient income in a pay period to cover the required contribution in addition to other required deductions (e.g. OBRA retirement). If the contributions are not withheld, I remain responsible for making timely payment(s) to the University in order to maintain my coverage intact.

3. I acknowledge that health insurance premiums and employee contributions are subject to change based on the health insurance contract and the University's bargaining agreement with the union representing my University position.

☐ I am a Postdoctoral Research Fellow at the University of Massachusetts Amherst. I acknowledge my portion of the health insurance premium will be charged to my fellowship at the University in order to secure and retain coverage:

Speedtype: _____

Fund: _____

Finance Dept. ID: _____

Sponsored Project Number: _____

If you are uncertain about any of these identifiers please obtain this information from your faculty sponsor or department's fellowship contact.

Signature: _____ Date: _____