

**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: _____