



2009 POSTDOCTORAL FELLOW BENEFITS ENROLLMENT

FOR FULL-TIME POSTDOCTORAL CLINICAL FELLOWS AND POSTDOCTORAL RESEARCH FELLOWS NOT RECEIVING SALARY

TIME-SENSITIVE: COMPLETE WITHIN 31 DAYS OF START DATE

PERSONAL INFORMATION (to be completed by the postdoctoral fellow)

Name: \_\_\_\_\_ UNI/Employee ID: \_\_\_\_\_
Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_
Home Phone: ( ) - \_\_\_\_\_
Department: \_\_\_\_\_ E-mail: \_\_\_\_\_

MEDICAL AND DENTAL PLANS (to be completed by the postdoctoral fellow)

Please check off one of the following medical coverage options. For plan details, consult Benefits in Brief for Officers, available on the web at www.hr.columbia.edu/hr/benefits-page-section.html.

Important Notes: HIP HMO requires a special enrollment form that is available at www.hr.columbia.edu/hr/.

CIGNA POS plan requires a Primary Care Provider (PCP) Selection form, also available at www.hr.columbia.edu/hr/.

\*Relationship codes:

PDF=Post-Doctoral Fellow / SP = Spouse / DP = Same-Sex Domestic Partner

Table with columns: MEDICAL PLANS, Individual, PDF & SP/DP, PDF & Child(ren), Family Plan. Rows include CIGNA Point-of-Service, UHC Point-of-Service, Aetna Point-of-Service II, CIGNA Modified Indemnity, HIP HMO, Aetna HMO, and DENTAL PLAN Aetna Dental.

DEPENDENT INFORMATION (to be completed by the postdoctoral fellow)

Indicate the dependent(s) you wish to cover under your medical plan. Please know that you must be prepared to provide proof of each dependent's eligibility if you are selected for audit at any time:

Dependent #1 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Dependent #2 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Dependent #3 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Relationship codes: SP = Spouse / DP = Same-Sex Domestic Partner / SO = Son / DA = Daughter / LG = Legal Guardian

P.D. Fellow Signature \_\_\_\_\_ Date \_\_\_\_\_

DEPARTMENT INFORMATION (TO BE COMPLETED BY THE DEPARTMENTAL ADMINISTRATOR)

I. PAYMENT OPTIONS (CHECK ONE OF THE FOLLOWING THREE OPTIONS):

Department pays full cost (IDI in advance) P.D. fellow pays full cost (monthly premiums)

Department pays part of the cost (IDI in advance) & postdoctoral fellow pays part (monthly premiums)

Department portion: \$ \_\_\_\_\_ Postdoctoral fellow portion: \$ \_\_\_\_\_

II. POSTDOCTORAL FELLOW'S APPOINTMENT EFFECTIVE DATE: \_\_\_\_\_

Dept. Admin. Signature \_\_\_\_\_ Date \_\_\_\_\_

Send Completed Form to:
Benefits Accounting, 615 West 131st Street, 4th Floor, MC 8703
New York, NY 10027