POSTDOCTORAL FELLOW
2017 BENEFITS ENROLLMENT FORM

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

TIME-SENSITIVE: Submit this form to your Departmental Administrator within 31 days of your date of hire to receive benefits.

PERSONAL INFORMATION (to be completed by the postdoctoral fellow)

Last Name: ____________________________________________ First Name: __________________________

UNI: __________________________ Email: __________________________

Home Address: __________________ City/State/Zip: __________________________

Phone: ( ) — Alternate Phone: ( ) —

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

Please check the desired coverage level* with the associated monthly contribution for one of the following medical coverage options. For plan details, please view http://hr.columbia.edu/links-especially/benefits-postdocs.

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>Coverage Levels &amp; Postdoctoral Fellow Monthly Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice Plus 80</td>
<td>Yourself $28, Yourself &amp; Spouse or Same-Sex Domestic Partner $28, Yourself &amp; Child(ren) $28, Family $28</td>
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<tr>
<td>Aetna Dental</td>
<td>Yourself $42, Yourself+ One $84, Family $125</td>
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DEPENDENT INFORMATION (to be completed by the postdoctoral fellow)

Enter all dependents who are to be covered under the Plan you selected and check the appropriate box to indicate which benefits apply to each dependent. You must be prepared to provide proof of each dependent’s eligibility if you are selected for audit at any time. To provide your dependent’s Social Security Number, call the Columbia Benefits Service Center at 212-851-7000.

Dependent #1
- Medical Coverage
- Dental Coverage
- Name: __________________________
  Relationship: __________________________ Date of Birth: __/__/____ SSN (Required): Call Columbia Benefits Service Center

Dependent #2
- Medical Coverage
- Dental Coverage
- Name: __________________________
  Relationship: __________________________ Date of Birth: __/__/____ SSN (Required): Call Columbia Benefits Service Center

Dependent #3
- Medical Coverage
- Dental Coverage
- Name: __________________________
  Relationship: __________________________ Date of Birth: __/__/____ SSN (Required): Call Columbia Benefits Service Center

Dependent #4
- Medical Coverage
- Dental Coverage
- Name: __________________________
  Relationship: __________________________ Date of Birth: __/__/____ SSN (Required): Call Columbia Benefits Service Center
PLEASE NOTE: INTERNAL REVENUE CODE SECTIONS 104 AND 105 REQUIRE THAT CONTRIBUTIONS MADE BY YOUR DEPARTMENT OR YOUR GRANT FOR MEDICAL AND/OR DENTAL COVERAGE ARE INCLUDED AS TAXABLE INCOME FOR YOU. IMPUTED INCOME MEANS YOU PAY TAXES ON THE COST OR VALUE OF THE BENEFITS. IMPUTED INCOME IS REPORTED ANNUALLY ON YOUR W-2 OR 1099.

P.D. Fellow Signature______________________________ Date__________________

DEPARTMENT INFORMATION (TO BE COMPLETED BY THE DEPARTMENTAL ADMINISTRATOR)

I. MEDICAL PAYMENT - Total medical contributions must equal $800 per month

- P.D. Fellow contribution (no more than $28 per month): ________________________
- PI/Department contribution:____________________________________
- Fellowship Allowance contribution (no greater than 75% of the total fellowship allowance*):____________________

Total Fellowship/Training Grant Allowance: ____________________________________________

*Questions related to fellowship allowance use should be directed to the Office of Postdoctoral Affairs or Sponsored Projects Administration

II. DENTAL PAYMENT – See monthly contributions on Page 1

☐ PI/Department pays full cost
☐ P.D. fellow pays full cost
☐ Fellowship Allowance pays full cost
☐ Cost split between PI/Department and Fellow – please explain breakdown of cost below:
  ☐ PI/Department pays: __________
  ☐ P.D. fellow pays: __________
  ☐ Fellowship Allowance pays: __________

III. POSTDOCTORAL FELLOW’S APPOINTMENT EFFECTIVE DATE: ________________________________

POSTDOCTORAL FELLOW’S APPOINTMENT END DATE:________________________________________

Dept. Admin. Signature__________________________________ Date__________________

Departmental Administrators: Please return this completed Form and the Interdepartmental Invoice (IDI) to Shawn Hayes, Benefits Specialist, at sh2276@columbia.edu at the Columbia Benefits Service Center. If you have any questions, please call 212-851-7000.

Return this Form to your Departmental Administrator within 31 days of your date of hire