SUNY RF

☐ **New Enrollment** (Waiting periods apply. Please refer to *Benefits Handbook*.)
☐ **Late Enrollment** (Please refer to *Benefits Handbook* for rules on late enrollment.)
☐ **Open Enrollment** (Waiting periods apply. Please refer to *Benefits Handbook*.)

☐ **Change:** ☐ **Coverage** (Complete Parts A, B, C, D, E, F
☐ **Health Plan** (Complete Parts A, B, D, E, F)
☐ **Name** (Complete Parts A, F)

Benefits Enrollment Form- POSTDOCTORAL FELLOW

PART A Legal Marital Status: ☐ Married ☐ Not Married | Sex: ☐ Male ☐ Female | Date of Birth: | | | Employment Date: | |

Name: (LAST / FIRST / MI) | FORMER LAST NAME (IF CHANGED) | EMPLOYEE NUMBER

Address: (STREET OR P.O. BOX / CITY / STATE / ZIP CODE) | TELEPHONE ( ) | E-MAIL ADDRESS

PART B **MEDICAL INSURANCE COVERAGE** ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Name (Additional form required): ☐ Grad Student/ Postdoc Health Plan ☐ I Decline Coverage

Please choose one of the following if enrolling in a medical plan other then the Grad Student/Postdoc Health Plan:

☐ **Individual only** ☐ **Individual & Children** ☐ **Individual & Family** ☐ **Individual & Spouse or Domestic Partner (Requires additional documentation and approval)**

Please choose one of the following if enrolling in the Graduate Student/ Postdoctoral Health Plan:

☐ **Individual only** ☐ **Individual + 1 dependent** ☐ **Individual + 2 or more dependents**

PART C* **DENTAL COVERAGE** ☐ Individual Only ☐ Family ☐ I Decline Coverage | **VISION PLAN** ☐ Regular ☐ Plus ☐ I Decline **Choose One**: ☐ Individual Only ☐ Family

* Completion of Part C is only required if electing medical insurance other then the Grad Student/Postodc Health Plan. Dental and vision are included in the Grad Student/Postodc Health Plan automatically.

PART D **DEPENDENTS – COMPLETE IN FULL – LIST ANY ADDITIONAL DEPENDENTS ON BACK OF THIS FORM**

ADD	DELETE	LAST NAME	FIRST NAME	MI	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	TYPE OF COVERAGE
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision

PART E **MEDICAL INSURANCE PLAN CHANGE** Date of change: | |

☐ Open Enrollment
☐ Moving out of area

From: ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Plan _____ ☐ Decline Coverage ☐ GradStudent/PD Health Plan

To: ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Plan _____ ☐ Decline Coverage ☐ GradStudent/PD Health Plan

DEPENDENT COVERAGE CHANGES Date of change: | |

Reason for change:

☐ Marriage ☐ Spouse's coverage terminated ☐ Newly eligible for coverage ☐ Child reached age limit ☐ Other, specify _____ ☐ Dependent died ☐ Divorce ☐ Birth/Adoption

PART F I hereby authorize deductions of the amount required, if any, for the insurance indicated. This authorization will be in effect until revoked in writing. | FELLOW SIGNATURE | DATE

Health Effective Date	**Dental** Effective Date	**Vision** Effective Date	Campus Location