

Health Insurance Options Form

For Post Doctoral Fellows (Position Code 95, on training grant),
J-1 Visa Fellows, Visiting Scholars, & Psychiatry/Psychology Interns

FOR OFFICE USE ONLY:

Insurance Effective Date: _____

YOUR PERSONAL INFORMATION (Please print.)

Gender M F Marital Status Single Married

Social Security #: |__|__|__| - |__|__| - |__|__|__|__|

Last Name: _____ First Name, Middle Initial: _____

Local Rochester Address: _____
Street or Box Number City State Zip Code

Home Phone Number: (____) _____ Work Phone #: (____) _____

E-mail Address: _____ Date of Birth: |__|__| \ |__|__| \ |__|__|__|__|
Month Day Year

University Department: _____ Appointment Dates: From _____ to _____

SPOUSE'S INFORMATION Marriage Date: _____ Social Security #: _____
(MM/DD/YYYY)

Name: _____ Date of Birth: _____ Gender M F
(MM/DD/YYYY)

INFORMATION ABOUT DEPENDENT(S)

Name: _____ Date of Birth: _____ M F
(MM/DD/YYYY)

Name: _____ Date of Birth: _____ M F
(MM/DD/YYYY)

ENROLLMENT OPTIONS (Check the appropriate box. Sign and date on the appropriate line.)

- Blue Cross Blue Shield for individual student** plus coverage provided by the mandatory health fee.
\$1,728/year (\$432/quarter)

Signature Date
- Blue Cross Blue Shield for student and spouse** plus the mandatory health fee for both.
\$3,456/year (\$864/quarter)

Signature Date
- University High Deductible Plan family insurance** plus coverage provided by the mandatory health fee for you.
\$1,060.80/month You must also complete the University High Deductible Plan Enrollment Form.

Signature Date
- Mandatory Health Fee only** (UHS office visits only). You have your own health insurance.
\$600/year (\$150/quarter)

Signature Date

PAYMENT ARRANGEMENTS: Check appropriate boxes. Sign and date on line at the bottom of the box.

If you check "Payment by Fellow/Scholar," your payment must accompany your form. You can bring your form to the UHS Insurance Advisor in Room 204 in the UHS Building on the River Campus or fax or mail your form if paying by credit card.

- Payment by Department:** [FOR OFFICE USE: Requisition # _____ Account # _____]
- Payment by Fellow/Scholar.** (Check one box on each line below. Sign at the X.)
Check One: Payment in full Quarterly payment * (Option 1, 2 or 4 only) Monthly payment * (Option 3 only)
Check One: Check written to UHS MasterCard VISA Expiration
For payment by credit card: Account # _____ Date _____

* If you checked the quarterly or monthly payment plan, sign that you read this statement: I understand that payment must be received by the first of each month. If I do not pay by the due date, my enrollment in the insurance plan I selected will be cancelled. If I choose to re-enroll in the plan, I understand that waiting periods will apply.

Signature Date