## Columbia University Medical Center Campus 2015-2016 Post-Doctoral Health Insurance Enrollment Application Student Health Service / Aetna Student Health Insurance

## 1. COMPLETE ALL INFORMATION: PLEASE PRINT LEGIBLY.

| Name:                        |            |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
|------------------------------|------------|-----------------|--------------------------------------|---------------------|------------------|------------------------|-------------------|---------|------------------------------|---|----------------|-------|--|
| Name:Last Name               |            |                 | First Name UNI ID #Email Address:    |                     |                  |                        |                   | MI      |                              |   |                |       |  |
| Employee ID #:               |            |                 | _UNI ID #                            |                     | Email Ad         | ldress:                |                   |         |                              | D.O.E   | mm/dd/vvv      |       |  |
| Mailing Addres               | s:         |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
| City:                        |            | Sta             | ate:                                 | _Zip Co             | ode:             |                        | Phone             | Numl    | er:                          | A   | pt. #<br>      |       |  |
| Gender: □ Mal                | lo □ Fomol | lo Eu           | .11 CCN.                             |                     |                  |                        |                   |         |                              |   |                |       |  |
|                              |            |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
| □ Postdoctoral l             |            |                 | INTMENT D  ☐ Postdoctora             |                     |                  |                        |                   |         |                              |   |                |       |  |
| □ NEW APPOI                  |            | enow            | □ REAPPOIN                           |                     |                  |                        | ADI W T           | EDM     | NATIO                        | NT#   |                |       |  |
|                              |            |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
| _                            | _          |                 |                                      | <u>tice</u> prio    | r to early       | terminati              | ion and           | retroa  | ctive ter                    | minations will no                               | t be granted.  |       |  |
| 2. <u>CONFIRM</u>            | 1 ENROLI   | <u>LMENT</u>    | PERIOD                               |                     |                  | _                      |                   |         |                              |   |                |       |  |
| Effective Date               |            |                 |                                      | Termination Dates   |                  |                        |                   |         |                              |   |                |       |  |
| <b>Dependents M</b>          | UST have   | the sam         | e enrollment (                       | dates as            | the Post         | t –Doctor              | al Fello          | w.      |                              |   |                |       |  |
|                              | HE AMOL    | NIT OF          | COVEDACI                             | E ANID I            | METHO            | DOEDA                  | X/N // TONI       | T       | Depar                        | tmental Administ                                | rators, per IR | S     |  |
| INDICATE TO                  |            |                 |                                      |                     |                  | d. & Spou              |                   | 1       | tions, you <u>must</u> s     | * <b>=</b>                                      |                |       |  |
| coverage is a                |            |                 | nt Health: 🗆 🗎                       |                     |                  |                        |                   | nily    |                              | will be reimbursi                               |                | ment  |  |
| The Description              | 4          | C               | _ 1                                  |                     |                  |                        |                   |         | the cost of their insurance. |   |                |       |  |
| The Department will pay for: |            |                 |                                      | □ Individual □ Ind. |                  |                        | & Spouse   Family |         |                              | Administrator's Signature                       |                |       |  |
|                              |            |                 |                                      | A                   | ARC CH           | ARTSTR                 | ING               |         |                              |   |                |       |  |
|                              |            |                 |                                      |                     | PC               |                        |                   |         |                              |   |                |       |  |
| <b>Business Unit</b>         | Accou      | ınt             | Department                           |                     | BUS<br>Unit      | P                      | Project           |         | Act.                         | Initiative                                      | Segment        | Site  |  |
|                              |            |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
| The Fellow is r              | oananaihla | for nov         | monts = V                            | 22                  |                  | I.o.                   |                   |         |                              |   |                |       |  |
|                              |            |                 |                                      |                     |                  |                        | r, Apt. 3         | BE. By  | signing                      | this form, the de                               | partment       |       |  |
|                              |            |                 |                                      |                     |                  |                        |                   |         |                              | on coverage, and i                              |                | ment. |  |
| 3. <u>LIST DEP</u>           | ENDENTS    | S TO BE         | E INSURED.                           | Enrol               | lled Spot        | ises/Dome              | estic Par         | rtners  | will be                      | charged for the S                               | Student Healt  | h     |  |
| Dependents                   | Last Na    |                 | First Na                             |                     | ces Fee ii<br>D0 |                        | to the i          |         | nce pre<br>Depende           | mium.<br>nt Email                               | Dependent Phon | e No. |  |
| Spouse/Domestic<br>Partner   |            |                 |                                      |                     |                  |                        |                   |         | •                            |   | •              |       |  |
| Child                        |            |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
| Child                        |            |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
| Child                        |            |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
| 4 M.C.                       | D D        | 1 E .11 .       | (C'                                  |                     |                  |                        |                   |         |                              |   |                |       |  |
|                              |            |                 | w: (Signatur<br>ect to enroll as inc |                     |                  | lumbia Univ            | ersity to         | provide | Aetna St                     | udent Health with my                            | enrollment     |       |  |
|                              |            |                 |                                      |                     |                  |                        |                   |         |                              | m is true and I am av<br>ter determined that th |                |       |  |
|                              |            |                 |                                      |                     |                  |                        |                   |         |                              | other than eligibility.                         |                |       |  |
|                              |            |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
| Administrator's Name         |            | Administra      | Administrator's Signature            |                     |                  | Administrator's E-Mail |                   |         |                              | Date  |                |       |  |
| E.H. 1.C.                    |            |                 |                                      |                     |                  |                        |                   |         |                              |   |                |       |  |
| Fellow's Signature           |            | Department Name |                                      |                     |                  | Phone Ext.             |                   |         |                              | Date  |                |       |  |

NEW APPOINTMENT - Please have Fellow bring application to: Haydee De Jesus, located at the CUMC Student Health Services, 60 Haven Ave., Apt. 3D, New York, NY 10032.

REAPPOINTMENT - PLEASE E-Mail. It is the responsibility of the person faxing or mailing the form to confirm with Haydee De Jesus receipt by calling 212-305-3206 or by emailing her at <a href="https://doi.org/10.1007/hdf">https://doi.org/10.1007/hdf</a>.



## Student Health Service

Departmental Administrator

**Policy & Procedure:** The following policy and procedures shall govern enrollment, termination and billing of Post Doctoral Fellows (PDFs) and their dependents, beginning August 15 (the beginning of the new insurance year) to protect the financial interests of the students of CUMC and effectively manage the administration of PDF enrollment.

| itial         | 1.      | Student Health Plan before   | e choosing to enroll. Informati   | of the Student Health Service (SHS) and Aetricon about Aetna and SHS can be found at or  | ur             |
|---------------|---------|--|---|--|----------------|
| DF            |         | adult dependents may incur   | costs if they seek care outside ferral from SHS). A three mont                      | olling in Aetna Student Health. <u>PDFs and the the SHS without prior authorization</u> (most visith minimum enrollment is required for the Aetro-   | its            |
|               | 2.      | packet which will include:  a. a valid employee numb. a copy of this signed  | mber,<br>and initialed Policy and Proce   | r contact the SHS with a completed enrollmendure,  | nt             |
|               |         |  | ace without the Employee ID   | number. The same form is submitted for rehe end date on the initial enrollment.  | e-             |
| nitial<br>PDF | . 3.    | enrollment. According to department is considered the end of the year. If an | IRS Regulations insurance to be taxable income and wi individual PDF requests insta | collment form must be paid in full at the time of coverage for PDFs paid for through the coverage on the fellow's W-2 or 1099 and the coverage of the full cost of individual and dependent of the full cost of the full cost of individual and dependent of the full cost of the f | ne<br>at<br>ne |
| nitial<br>DA  | 4.      | the original enrollment form<br>date section is found on the                 | n). This is <b>required</b> for any r<br>Enrollment form. Fill out and s            | ce (ie, termination before the date indicated of funds to occur. The early termination submit to the SHS one month before termination mination will be responsible for all insurance.  | on<br>n.       |
|               |         | e read and reviewed this polinced above.                                     | cy as well as the Aetna Stude   | ent Health and Student Health Service Materia  | ls             |
| P             | ost Doc | ctoral Signature   | Print Name  | Date   |                |
|               |         |  |   |  |                |

Print Name/Department

Date