COLUMBIA UNIVERSITY
HR Benefits

POSTDOCTORAL FELLOW
2017 BENEFITS OPEN ENROLLMENT FORM

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

TIME-SENSITIVE: Complete by November 18, 2016 to make changes for the 2017 plan year

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.

Medical Plan	**Coverage Levels & Employee Monthly Contributions**							
Choice Plus 80	☐ Yourself	$28	☐ Yourself & Spouse or Same-Sex Domestic Partner	$28	☐ Yourself & Child(ren)	$28	☐ Family	$28
Dental Plan								
Aetna Dental	☐ Yourself	$42	☐ Yourself+ One	$84	☐ Family	$125		

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. PAYMENT

Postdoctoral Fellow contribution: _$336_

PI/Department contribution: _____

Fellowship Allowance contribution (no greater than 75% of the fellowship allowance):_____

Total Fellowship/Training Grant Allowance: _____

II. POSTDOCTORAL FELLOW'S APPOINTMENT EFFECTIVE 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 by November 18, 2016