RUTGERS UNIVERSITY
POSTDOCTORAL FELLOWS/GRADUATE FELLOWS/PARTIAL TAs-GAs HEALTH INSURANCE ENROLLMENT/CHANGE FORM 2024-2025

(PLEASE PRINT)

Name_____
Last First MI

Mailing Address_____
Street or PO Box City State Zip

Student ID #_____ Date of Birth_____ Phone#_____ Sex Assigned at Birth M / F

Email Address_____ **DATE OF RETENTION**_____/_____/_____
mm dd yyyy

SCHOOLS/DEPARTMENT:_____**ACCOUNT/GRANT #**_____

REASON FOR ENROLLMENT
□ New Post Doctoral/ Grad Fellow/Partial TA/GA
□ Annual open enrollment
□ Life Status Change
□ Other (explain in "Remarks" section below)

CHANGES TO EXISTING COVERAGE
□ Individual □ Family
□ Addition of a dependent
□ Change in application information
□ **TERMINATION OF COVERAGE DATE** _____/_____ /_____
mm dd yyyy

REMARKS:

If you are enrolling Dependents, list Dependents to be insured below.
Dependent coverage is available ONLY if the Post Doctoral Fellow, Grad Fellow, or Partial TA/GA is also insured under the Plan.

	Last Name	First Name	MI	Date of Birth	SS#	Sex Assigned at Birth
Spouse:						
Child:						
Child:						
Child:						

Annual Rate	Student	Spouse	Each Child	Two or More Children	Spouse + Two or More Children
Medical Policy #2024-202826-1	$2,942	$2,942	$2,942	$5,884	$8,826
Unum Life & AD&D Policy **	$21.60	n/a	n/a	n/a	n/a
Total Annual Rate	**$2,963.60**	**$2,942**	**$2,942**	**$5,884**	**$8,826**

NOTE: Coverage will become effective on the same date the insured's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with termination provisions described in the Master policy.

NOTICE: Coverage will be effective from the date of retention by the University or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master policy. By signing, the postdoctoral fellow/graduate fellow/partial TA-GA acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form; 2) He/She meets the eligibility requirements for this coverage as described in the brochure; and 3) If it is later determined that the postdoctoral fellow/graduate fellow/partial TAs-GAs is not eligible, the premium will be refunded provided no claims have been filed.

SIGNATURE:_____ DATE:_____

Please contact University Health Plans at info@univhealthplans.com or (833) 251-1142 if you have any questions about enrolling yourself or dependents in the plan.

- *Coverage is underwritten by: UnitedHealthCare Insurance Company* *** Unum Life Insurance Beneficiary Form Has Been Completed* ☐ *(check box)*

*ADMINISTRATION SIGNATURE:*_____*TITLE:*_____*DATE:*_____

COPY 1 – RUTGERS DEPT. *COPY 2 –RISK & CLAIMS OFFICE.* *COPY 3 - ENROLLEE*