Oregon Health & Science University Postdoctoral Scholars
Benefit Enrollment and Update Form

This form replaces any prior enrollment form. Complete this form to enroll or make changes to your medical/dental insurance coverage. Benefit election changes must be on account of and consistent with the qualified family status change, and must be requested and returned within 31 days of the qualified family status change. **COMPLETE ALL SECTIONS**

ID or SSN _____ **Date of Birth** _____ **Sex** Male ◯ Female ◯

Last Name _____ **First Name** _____ **MI** _____ **Contact Phone** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Date of Hire _____ **Department** _____

New Enrollment ◯ **Change** ◯ **Reason for Change** _____ **Date of Change** _____

LIST ALL DEPENDENTS TO BE COVERED INCLUDING THOSE ALREADY COVERED BY PLAN

Dependent Name	Date of Birth	Sex (M/F)	Relationship	Medical Coverage	Dental Coverage
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

If you are *opting out of* medical and/or dental coverage please complete the information below:

Employer: _____ **Medical Insurance Company:** _____ **Group Number:** _____ **Policy Number:** _____

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I attest that I have comparable group insurance that is currently in effect with no scheduled termination date. Should I lose my coverage at any time, I am responsible for notifying the Postdoc Benefits Liaison of such change in order maintain the required level of insurance coverage.

I understand the elections I have made are in effect so long as eligibility requirements are met until I elect to change them subject to the provisions of each plan. Benefit costs in excess of my OHSU department contribution will deducted from my pay or stipend. I have read the benefit materials and understand the limitations and qualifications of the OHSU Postdoctoral Scholars benefits program. I authorize any medical care institution, medical provider, or dentist to furnish my medical and/or dental carrier with any information related to the physical or mental condition, medical history, or medical/dental treatment of me or my dependents when administering claims under my policy. This authorization will remain valid until a new document has been signed and submitted.

Signature _____ **Date** _____

Please return this completed form to the Postdoc Benefits Liaison, MC: L335 Fax: 503-494-1099 Email: postdocinfo@ohsu.edu

Postdoc Benefits Liaison Office Use Only	
Medical Effective Date	
Dental Effective Date	
Completed On	
Completed By	