Human Resources

MIT POSTDOCTORAL FELLOW DENTAL & VISION ENROLLMENT/CHANGE FORM

1. PERSONAL INFORMATION:

Last Name:	First Name:	Middle Initial:	Telephone number:
MIT ID Number:	Gender:	Date of Birth:	Email address:

2. ENROLLMENT/TERMINATION OF COVERAGE/QUALIFYING EVENT INFORMATION:

☐ Enroll During Open Enrollment (Effective January 1st of next year)

☐ Terminate Coverage During Open Enrollment (Effective January 1st of next year)

☐ New Hire/Newly Eligible
Date of Hire/New Eligibility: _____

Choose coverage start date:
☐ Date of Hire/New Eligibility
☐ 1st of month following Date of Hire/New Eligibility

☐ Qualifying Event*
☐ Date of Event: _____

*See next page for required documentation

☐ Marriage/Partnership	☐ Obtaining Other Coverage
☐ Birth/Adoption	☐ Loss of Other Coverage
☐ Divorce/Termination of Partnership	☐ Change in Medicaid or SCHIP eligibility
☐ Death of Dependent	☐ Other

3. BENEFIT PLAN SELECTIONS/COVERAGE LEVEL:

Dental Plan	Individual	Employee + Spouse (or Partner)	Employee + Child(ren)	Family	Terminate Coverage	Vision Plan	Individual	Employee + Spouse (or Partner)	Employee + Child(ren)	Family	Terminate Coverage
Basic						Vision Plan					
Comprehensive											

4. INFORMATION ABOUT COVERED MEMBERS:

Name (Last, First, Middle)	**Gender**	**Date of Birth** (MM/DD/YY)	**Dental Coverage**	**Vision Coverage**
Employee	(Information listed in Section 1)		(Indicated in Section 3)	
☐ **Spouse** ☐ **Partner**			☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate
Dependent*			☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate
Dependent*			☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate
Dependent*			☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate
Dependent*			☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate

*Additional dependents may be attached on a separate page. Contact Benefits if you have a dependent age 26 or older who has a disability - additional paperwork is required.

5. ACKNOWLEDGEMENT/SIGNATURE:

I have received and reviewed information about my Dental and Vision plan choices. I certify that the information I have provided on this form is true and correct to the best of my knowledge. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages.

Signature:	Date:

For Office Staff Use Only:

SAP updated by:	Date:	Comments:

77 Massachusetts Avenue
Building NE49-5000
Cambridge, MA 02139-4307
http://hrwed.mit.edu/benefits

Email: benefits@mit.edu
Phone: 1-855-253-6151
1-617-253-6151
Fax: 1-617-253-2694

Examples of Documentation Required for Validating Dependent Eligibility in MIT Dental Plans

Dependent Type	Documentation Needed
Spouse	Marriage Certificate
Partner	MIT Affidavit of Partnership for Benefits Eligibility
Birth child up to age 26	Birth Certificate showing name of child and name of employee
Adopted child up to age 26	Adoption Certificate showing name and date of birth of child and name of employee
Step-child up to age 26	Birth Certificate showing name of child and spouse's/partner's name AND Marriage Certificate/Affidavit of Partnership showing employee's name and spouse's/partner's name
Child up to age 26 for whom you are the Legal Guardian	Proof of Legal Guardianship AND Birth Certificate
Child with a mental or physical disability up to age 26 or older who is not able to earn his or her own living	Appropriate documentation as listed above for birth, adoption or legal guardian status AND Certification by Medical Plan
Child recognized under a Qualified Medical Child Support Order	Qualified Medical Child Support order AND Birth Certificate
Birth child of an enrolled dependent child (as defined above)	Birth Certificate showing name of birth child and name of your enrolled dependent child
Divorced Spouse	Please contact the Benefits Office

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