NOTICE OF CONTINUATION OF HEALTH PLAN ENROLLMENTS

I, _____, hereby notify MIT Benefits, that I am continuing my:

☐ Medical plan enrollment that was in effect on the day before my Postdoctoral Fellowship commenced at MIT with no changes to the plan

☐ Dental plan enrollment that was in effect on the day before my Postdoctoral Fellowship commenced at MIT with no changes to the plan

☐ Vision plan enrollment that was in effect on the day before my Postdoctoral Fellowship commenced at MIT with no changes to the plan

I understand that in continuing my health plan(s) as mentioned above, I will be responsible to pay the full, 100% unsubsidized rate(s) and that I will be home billed by MIT for this coverage.

If you wish to continue your coverage with no changes, this notice must be submitted within 31 days of the commencement of your Postdoctoral Fellowship.

Name: _____

MIT ID Number: _____

Signature: _____

Date: _____

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

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