

Postdoctoral Scholar – Fellow (Title Code 3253)

Opt- Out Form: Health Premium Deductions

*Submit this form ONLY if you choose not to participate
in the University deduction service.*

This form serves as notice to the University that I wish to decline enrollment in the monthly health premium deduction service provided by the University. Further, I understand that I will be billed by the University’s Third-Party Postdoctoral Scholar Benefit Plan Administrator for the appropriate costs for my monthly health premiums.

Print Name

Signature

Date

Mobile Phone Number

Work Phone Number

Email

Department

Work Location
(Building & Room #.)

P.I./Lab/Research Group

Home Address
(Number & Street)

Home Address (City)

Home Address (Zip Code)