NC STATE UNIVERSITY
DIVISION OF HUMAN RESOURCES

Post-Doc/House Officers Medical Coverage

Post-Doc/House Officers Information

☐ I am a U.S. Citizen/U.S Permanent Resident ☐ I am a Foreign National

Employee ID _____ Date of Birth _____ ☐ Male ☐ Female

First Name _____ Middle _____ Last Name _____

Address _____ City _____ State _____ Zip Code _____

Academic Department & College _____ Campus E-Mail _____

Campus Phone Number _____ Campus Box Number _____ Hire Date _____

Supervisor _____ Supervisor E-Mail _____

☐ I want to enroll in the Health Plan.

I ***will participate*** in the Post Doc/House Officers Group Health Plan and will have access to the NC State Student Health Service as explained in NC State's "Requirements for the Employment of Post Doc/House Officers." I understand that NC State will pay my monthly premium for participation in the Post Doc/House Officers Group Health Plan and will pay my monthly NC State Student Health Service fee while I am employed as a Post Doc/House Officer at NC State. I understand that I may waive both the NC State Post Doc/House Officers Group Health Plan and the Student Health Service at anytime by resubmitting a signed Post Doc/House Officers Medical Coverage form and selecting the "I will not participate" option.

☐ I do not want to enroll in the Health Plan.

I ***will not participate*** in the Post Doc/House Officers Group Health Plan nor have access to the NC State Student Health Service as explained in the NC State's "Requirements for the Post Doc/House Officers." I understand that I may not reverse my decision unless I become ineligible for my current health plan. I understand that if I do not have a current health plan, I may not enroll in the Post Doc/House Officers Group Health Plan in the future. I understand the medical coverage options provided above.

The following applies to Foreign Nationals: I further understand that since I will not participate in the NC State plan, I am required to have insurance that will pay the costs of medical care for accidents, sickness, medical evacuation and repatriation and I certify that I have medical insurance which will cover me and all accompanying family members for the entire period of my stay in the U.S. If I am unable to obtain such coverage before arrival in the U.S., this certifies my intent to do so immediately upon arrival. I also certify that the insurance I have, or will obtain, provides coverage that includes amounts of minimum per accident or illness, maximum deductible per illness, provision for medical evacuation, and maximum repatriation coverage commiserate with current visa requirements.

Eligible dependents may also be enrolled in this plan if you are electing coverage. If you wish to enroll your eligible dependents, please contact Blue Cross Blue Shield NC at (919) 645-0240. Enrollment forms and additional information about the plan can be obtained at http://www.bcbsnc.com/content/student/ncsu/pd.htm

Employee Signature _____ Date _____

Submit completed form to HR Benefits:

Mailing Address:
Campus Box 7215
Raleigh, NC 27695

Fax Number: (919) 513-2528

Physical Address:
Administrative Services - Bldg II
2711 Sullivan Dr., Suite 200

Print Form

Questions about this form? Contact Benefits at (919) 515-2151