



## NOTICE OF CONTINUATION OF HEALTH ENROLLMENT

I, \_\_\_\_\_, hereby notify the MIT Benefits Office, that I am continuing my:

- Heath/Medical plan membership that was in effect on the day before my Postdoctoral fellowship commenced at MIT with no changes to the Plan.
  
- Dental Plan membership that was in effect on the day before my Postdoctoral fellowship commenced at MIT with no changes to the Plan.
  
- Vision Plan membership 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 benefit(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 appointment.

Name: \_\_\_\_\_

MIT ID Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_