



Fellow Election Form

Medical and Dental Plans

New Subscriber

First Name:		MI:	Last Name:	
Address:			Apt #:	
City:		State:	Zip Code:	
Social Security #:		Phone #:		
Date of Birth: (MM-DD-YYYY)	Sex Assigned at Birth*: ☐ M ☐ F		Marital Status: ☐ Single ☐ Married	
Personal Email:		Work Email:		
NED ID:		Full Time Hire Date: (MM-DD-YYYY)		
Award #:	Award Period: Start _____ End _____			
FAES USE:	Requested Effective Date: (MM-DD-YYYY)		New Hire ☐	Special Enrollment ☐
			Open Enrollment ☐	

DEPENDENTS

Name: (Last, First, MI)	Relationship to Subscriber:	Social Security #:	Birth Date (MM-DD-YYYY)	Sex Assigned at Birth*: M F	Same Address as Subscriber Y N
	Spouse			☐ ☐	☐ Y ☐ N
	Dependent			☐ ☐	☐ Y ☐ N
	Dependent			☐ ☐	☐ Y ☐ N
	Dependent			☐ ☐	☐ Y ☐ N
Spouse or Dependent's Address: (if address is different from subscriber)					

Institute (select one below):	Health Plan: AETNA Signature Administrators-PPO
☐ NCATS ☐ NIA ☐ NIDA ☐ NIMH ☐ CC ☐ NCCIH ☐ NIAAA ☐ NIDCD ☐ NIMHD ☐ CIT ☐ NCI ☐ NIAID ☐ NIDCR ☐ NINDS ☐ CSR ☐ NEI ☐ NIAMS ☐ NIDDK ☐ NINR ☐ FIC ☐ NHGRI ☐ NIBIB ☐ NIEHS ☐ NLM ☐ OD ☐ NHLBI ☐ NICHD ☐ NIGMS	Select Level of Coverage: ☐ Individual ☐ Family If your spouse works at the NIH, please list their full name here: _____

*Sex Assigned at Birth might be different from current gender identity.
FAILURE TO SELECT A SEX MAY RESULT IN CLAIM DENIALS.

Employee Signature:	Date
FAES Representative Signature:	Date