FOREIGN VISITING SCHOLAR COVERAGE WORKSHEET

Appointment Period July 1, 2009 – June 30, 2010

This worksheet cannot be used to make health coverage elections – it is an internal worksheet for departmental Business Administrators (BAs) only. Health coverage elections must be made via the benefits enrollment website at http://www.pennbenefits.upenn.edu or the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236). You must also complete and return this form to your departmental BA each time you enroll, waive or change your coverage.

Appointee Printed Name: _____ **PENN ID No.:** _____

Appointment Begin Date: _____ **End Date:** _____ **Coverage Effective Date:** _____

Bus. Admin. Printed Name: _____ **Dept.:** _____ **Home ORG:** _____ **Dept. Phone:** _____

The University requires that all Foreign Visiting Scholars be provided with Employee Only health insurance, the entire cost of which is funded by the sponsoring activity or department. You may also elect coverage for your dependents which, if your department or a private sponsor does not cover the additional cost, must be paid through payroll deduction from your stipend. You may waive medical coverage if you already have health insurance from another source and provide proof of insurance.

Federally sponsored activities will fund only Employee Only coverage (Category **A**). You may elect coverage for your dependents, and if your department elects to pay the additional premium, the additional cost of coverage for dependents must be supported by a non-federal source of funds (Category **B**). If the grant or department will only pay Employee Only coverage and you elect coverage for your dependents, the additional premium can be deducted from your stipend (Category **C**). Some private sponsors will allow funding of health coverage for dependents (Category **D**).

☐ ENROLLMENT ☐ *WAIVE HEALTH COVERAGE ☐ CHANGE IN HEALTH COVERAGE

***WAIVER: I hereby certify that I have health insurance coverage from _____ and waive coverage through the University of Pennsylvania. Attached is proof of alternate medical insurance.**

_____ _____ _____

(Appointee's Signature) **(Business Administrator's Signature)** **(Date)**

Please check all that apply in the following tables:

HEALTH PLAN	☐ Keystone/AmeriHealth HMO	☐ Aetna HMO	☐ UPHS/AmeriHealth POS	☐ PENNCare/Personal Choice

COVERAGE LEVEL	☐ Employee Only	☐ Employee + One Dependent	☐ Employee + Two or More Dependents	

FUNDING AGENT(S)	**Employee Only (no cost to Appointee)**	☐ A Grant Pays		
		CNAC/ORG/BGT/CHK/FUND/OBJ/PRO/C-REF:		
	Dependent Coverage	☐ B Department Pays (DP)**	☐ C Appointee Pays (AP)	☐ D Grant Pays (GP)**
		CNAC/ORG/BGT/CHK/FUND/OBJ/PRO/C-REF:		

PREMIUM(S)	(A) EMPLOYEE ONLY	(B OR C) 1 DEPENDENT	(B OR C) 2 OR MORE DEPENDENTS	(A + D) EMPLOYEE + 1 DEPENDENT	(A + D) EMPLOYEE + 2 OR MORE DEPENDENTS	FY 2010 TOTAL (rate x number of months)
Keystone HMO	☐ 394.54	☐ 512.91	☐ 749.64	☐ 907.45	☐ 1,144.18	
Aetna HMO	☐ 377.69	☐ 491.00	☐ 717.62	☐ 868.69	☐ 1,095.31	
UPHS POS	☐ 437.01	☐ 568.11	☐ 830.32	☐ 1,005.12	☐ 1,267.33	
PENNCare / Personal Choice	☐ 448.81	☐ 583.46	☐ 852.74	☐ 1,032.27	☐ 1,301.55	

**When the Grant or Department pays the Dependent Coverage, the BA must immediately contact Joseph A. Southerland via phone (215.898.0954), or e-mail (southerl@upenn.edu).

I understand that this worksheet does not constitute a valid health coverage election, and that I must make my elections via the benefits enrollment website at http://www.pennbenefits.upenn.edu or the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236). I further understand that I cannot change my health coverage election during the plan year (7/1/09 – 6/30/10) unless I experience a qualifying life event change in family status (as defined by the University of Pennsylvania Summary Plan Description) and request a change within 30 days of the qualifying event. Family members entering the country must be on a job "J" or "H" visa to be eligible for family coverage. Family members on a "B1" or "B2" visa are on a visitor's visa and are ineligible for coverage.

_____ _____ _____ _____

(Appointee Signature) **(Date)** **(Business Administrator Signature)** **(Date)**