FAES
FOUNDATION FOR ADVANCED EDUCATION IN THE SCIENCES

Employee Election Form

Medical, Dental and Vision Plans

New Subscriber

First Name:	**MI:**	**Last Name:**
Address:		**Apt #:**
City:	**State:**	**Zip Code:**
Social Security #:	**Phone #:**	
Date of Birth: (MM-DD-YYYY)	**Gender:** 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)	Gender M F	Same Address as Subscriber
	Spouse			M F	Y N
	Dependent			M F	Y N
	Dependent			M F	Y N
	Dependent			M F	Y N

Spouse or Dependent's Address: (if address is different from subscriber)

Institute (select one below):

OD NIAAA NIDDK NINDS CIT
NCI NIAID NIDA NINR NCRR
NEI NIAMS NIEHS NLM CC
NHLBI NIBIB NIGMS CSR NCATS
NHGRI NICHD NIMH FIC
NIA NIDCR NIMHD NCCIH

Health Plan: AETNA Signature Administrators-PPO

Select Level of Coverage:

Individual

Family

If your spouse works at the NIH, please list their full name here:_____

Employee Signature:	Date
FAES Representative Signature:	Date