



HILL, CHESSON & WOODY

Experience the benefit.

Hill, Chesson & Woody
P.O. Box 3617
Chapel Hill, NC 27515
Phone (919) 967-5900
Fax (919) 313-2020
www.hillchesson.com

UNC Postdoc Medical Insurance Policy

Frequently Asked Questions

What is the UNC Postdoc Insurance Policy? *It is a major medical policy underwritten by BlueCross BlueShield of North Carolina and managed by Hill, Chesson & Woody. Refer to the attached Summary of Benefits to see your benefits.*

How do I apply? *Complete the attached enrollment forms and return them to the department manager or HR facilitator and the manager or facilitator should mail them to the address above.*

Am I eligible? *In order to be eligible for the Postdoc Medical Insurance Plan, the Postdoc must be coded 27 or 28 and Temporary Full-Time with UNC Payroll.*

When does coverage begin? *Coverage begins on the Postdoc's appointment date.*

What if I do not want the policy? *Complete the attached waiver form and mail one copy to UNC Payroll as well as one to Hill, Chesson & Woody.*

How do I enroll dependents? *New Postdoc's have the ability to add dependents beginning the day the Postdoc's policy is effective. To enroll a spouse or dependent child/ren, write a check **payable to BCBSNC** for the first two months of premium and attach it to the BCBS insurance application. Future monthly premiums will be deducted from payroll. For existing Postdoc's, please call Hill, Chesson & Woody using the contact information above in order to determine if your dependents are eligible to come onto the policy and to obtain enrollment information including the correct prorated premium. ****Please note that the Campus Health Fee is a separate monthly charge of \$44.50 for spouses. Please contact Campus Health Services at 966-6588 for further questions related to this fee.***

When will I get my insurance card? *It typically takes about 45 days from the appointment date for the Postdoc to receive an insurance card. Coverage is retroactive to the appointment date. Hill, Chesson & Woody is notified of a Postdoc's eligibility at the end of the month following the appointment date. For example, if a Postdoc's appointment date is December 1, Hill, Chesson & Woody will be notified of that Postdoc's eligibility at the end of December and receive payments for December and January at that time.*

What if I need to see the doctor before I receive my insurance card? *You may have to pay for all or part of the charges when you are seen. After you receive your insurance card, you can give the provider's office a copy of your insurance card and ask them to file the claim for you.*

Additional information can be found at www.hillchesson.com. If you have any questions, please contact Jennifer H. at Hill, Chesson & Woody, at (919) 967-5900 or jenniferh@studentbluenc.com.



**PostDoc Blue Options
Dependent Insurance Application Form**
University of North Carolina 2009-2010

Please visit our web site at bcbsnc.com/UNC **PLEASE PRINT CLEARLY.**

Section I PostDoc Blue Options Dependent Application Form *

LAST NAME FIRST NAME BIRTHDATE MIDDLE INITIAL
 MONTH DAY YEAR SEX MALE FEMALE
 MAILING ADDRESS (STREET, ROUTE, BOX NUMBER, ETC.)
 CITY STATE ZIP SOCIAL SECURITY NUMBER (Required)
 P.I.D. NUMBER (Optional)
 DEPARTMENT AFFILIATION AREA CODE TELEPHONE NUMBER
 *Please see the legal notice on the reverse side of this application regarding special enrollment.

Section II Application for Dependents' Coverage *

I also hereby apply for the following members of my family:

SPOUSE SEX MALE FEMALE
 FIRST NAME INITIAL LAST BIRTHDATE MONTH DAY YEAR
 SOCIAL SECURITY NUMBER
CHILD 1 SEX MALE FEMALE
 FIRST NAME INITIAL LAST BIRTHDATE MONTH DAY YEAR
 SOCIAL SECURITY NUMBER
CHILD 2 SEX MALE FEMALE
 FIRST NAME INITIAL LAST BIRTHDATE MONTH DAY YEAR
 SOCIAL SECURITY NUMBER
CHILD 3 SEX MALE FEMALE
 FIRST NAME INITIAL LAST BIRTHDATE MONTH DAY YEAR
 SOCIAL SECURITY NUMBER
 *DEPENDENTS INCLUDE SPOUSE AND UNMARRIED DEPENDENT CHILDREN FROM BIRTH TO THE 26th BIRTHDAY

Section III Premiums

Spouse \$ 166.64 per month + Campus Health Fee
 Child/Children \$ 117.43 per month

Section IV Prior Insurance Information

It is very important that you provide all relevant information in full. Failure to do so may hinder processing of your claims.

I was covered under the University of North Carolina student plan provided by Blue Cross and Blue Shield of North Carolina (BCBSNC) during the 2008-2009 policy year.
 I have had no health insurance within the last 63 days.*
 I am currently covered, or have been covered within the past 63 days, by the following health insurance plan. BCBSNC may request a HIPAA certificate for verification purposes.

PREVIOUS INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
 AREA CODE TELEPHONE NUMBER POLICY NUMBER
 EFFECTIVE DATE OF POLICY MONTH DAY YEAR
 TERMINATION DATE OF POLICY MONTH DAY YEAR
 EMPLOYER (if applicable) MONTH DAY YEAR

Please check here if the above information is the same for all dependents listed on policy.
 Please check here if one or more dependents listed have different previous insurance information. A letter outlining each dependent's previous insurance information must be attached.
 *Please see the legal notice on the reverse side of this application regarding coverage of pre-existing conditions.

Section V Statement of Understanding

I understand that by signing below, I am agreeing to the following:
 I certify that all statements on this application are complete and true. I understand that for a period of two years from the date coverage is issued, Blue Cross and Blue Shield of North Carolina (BCBSNC) may void or terminate my coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, BCBSNC may take legal action at any time.
 I understand that any coverage provided according to this application will be subject to the provisions of the contract including the benefit booklet provided to me by BCBSNC.
 I have read and understand the legal notices on the reverse side of this application regarding coverage of pre-existing conditions and special enrollment.

SIGNATURE OF PRIMARY APPLICANT _____ DATE MONTH DAY YEAR

Section VI Payroll Deduction

For PostDocs insuring their dependents beginning July 1, 2009, please submit a check for two (2) months for the period beginning July 1, 2009 through August 31, 2009. A payroll deduction will be made on August 31, 2009 for the period beginning September 1, 2009 through September 30, 2009. Deductions will continue each month throughout the Postdoctoral appointment. For PostDocs insuring dependents beginning after July 1, 2009, please provide a check for the first two (2) months. Additional monthly deductions will be made through payroll.

I hereby authorize the University of North Carolina to deduct from my salary/wages my premium applicable to the enrollment of my dependents in the University of North Carolina PostDoc Medical Insurance Plan.

SIGNATURE _____ DATE MONTH DAY YEAR
 DEPARTMENT AFFILIATION _____

Mailing Address: Blue Cross and Blue Shield of North Carolina, P.O. Box 3617, Chapel Hill, NC 27515-3617
Questions? Call Student Blue at 919-967-5900 or email@studentblue.com

IMPORTANT LEGAL NOTICES SPECIAL ENROLLMENT

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and the dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed, or within 60 days after the loss of Medicaid or Children's Health Insurance Program (CHIP) eligibility for you and your dependents.

For questions or to obtain more information, contact:

Blue Cross and Blue Shield of North Carolina

P.O. Box 3617 Chapel Hill, NC 27515-3617

919-967-5900

COVERAGE OF PRE-EXISTING CONDITIONS

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to children added as a result of a court order, or to a child who is enrolled in the plan within 30 days of birth, adoption, or placement for adoption or foster care. Eligible children (newborns, adoptive children and foster children) are not subject to this exclusion period when enrolled more than 30 days after one of the events listed above if your coverage type or the premiums owed are not affected by adding the child. When applicable, this exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage".

Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact Blue Cross and Blue Shield of North Carolina if you need help demonstrating creditable coverage. Throughout this notice: all references to "you" are meant to refer to the subscriber and their dependents, and all references to "us" and "we" are meant to refer to Blue Cross and Blue Shield of North Carolina.

For questions or to obtain more information, contact:

Blue Cross and Blue Shield of North Carolina

P.O. Box 3617 Chapel Hill, NC 27515-3617

919-967-5900

Blue OptionsSM Benefit Highlights (PPO)

	In-network	Out-of-network ¹
Campus Health Services (<i>Medical Services</i>)	100%, no deductible	Not applicable
Physician Office Visit		
<i>Includes Office Surgery, Consultation, X-rays, Lab and benefit period maximum of 4 office visits for the assessment of obesity in and out of network.</i>		
Primary Care Provider	90% after deductible	70% after deductible
Specialist	90% after deductible	70% after deductible
Preventive Care		
<i>Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)</i>		
Primary Care Provider	90% after deductible	Not Available*
Specialist	90% after deductible	Not Available*
<i>*Pap Smears, Mammograms and PSAs are covered Out-of-network.</i>		
Therapies		
<i>Short-Term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):</i>		
<i>Physical/Occupational: 30 visits per Benefit Period</i>		
<i>Speech Therapy: 30 visits per Benefit Period</i>		
Primary Care	90% after deductible	70% after deductible
Specialist	90% after deductible	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	90% after deductible	90% after deductible
Emergency Room Visit (<i>Inpatient Hospital benefits apply if admitted. If held for Observation, Outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".</i>)	90% after deductible	90% after deductible
Ambulatory Surgical Center	90% after deductible	70% after deductible
Inpatient and Outpatient Hospital Services		
Hospital, Hospital Based Services and Outpatient Clinic Services	90% after deductible	70% after deductible
Professional Services	90% after deductible	70% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms	90% after deductible	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests, such as EEG's and EKG's	90% after deductible	70% after deductible
CT scans, MRI's, MRA's and PET scans in any location, including physician's office	90% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility (<i>60 days per Benefit Period</i>)	90% after deductible	70% after deductible
Home Health Care, Ambulance,	90% after deductible	70% after deductible
Durable Medical Equipment and Hospice		
Maternity (<i>Maternity Delivery includes Prenatal and Post-delivery care</i>)		
Hospital Services (Delivery)	90% after deductible	70% after deductible
Professional Services (Delivery)	90% after deductible	70% after deductible
Transplants		
Hospital Services	90% after deductible	70% after deductible
Professional Services	90% after deductible	70% after deductible
Infertility Services (<i>Up to \$5,000 per Lifetime</i>)		
Primary Care Provider	90% after deductible	70% after deductible
Specialist	90% after deductible	70% after deductible
Hospital Services	90% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	90% after deductible	70% after deductible
Vision Care		
Comprehensive Eye Exam	90% after deductible	Not applicable

Blue OptionsSM Benefit Highlights (PPO)

Lifetime Maximum, Deductibles & Coinsurance Maximums

The following Deductibles and Coinsurance Maximums apply to the services on the previous page [and Mental Health and Substance Abuse services below]:

	In-network	Out-of-network ¹
Lifetime Benefit Maximum		Unlimited
Deductibles		
Individual (per Benefit Period)	\$100	\$200
Family (per Benefit Period)	\$300	\$600
Coinsurance Maximum		
Individual (per Benefit Period)	\$1,000	\$2,000
Family (per Benefit Period)	\$3,000	\$6,000

Mental Health and Substance Abuse Services

*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.

	Certified*	Non-Certified ¹
Mental Health Services		
Office (40 visits per Benefit Period)	90% after deductible	70% after deductible
Inpatient/Outpatient (30 days per Benefit Period)	90% after deductible	70% after deductible
<i>(Certain mental health conditions do not have visit limits. For a list of these conditions, refer to your benefit booklet.)</i>		
Substance Abuse Services		
Office Visit	90% after deductible	70% after deductible
Inpatient/Outpatient	90% after deductible	70% after deductible
Benefit Period Maximum	\$8,000	
Lifetime Maximum	\$16,000	

Prescription Drugs

Campus Health Services

Generic or Brand (30 day supply) \$10 copayment Not applicable

Other Pharmacy

Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. Infertility Drugs up to \$5,000 per Lifetime.

MAC C Pricing.

Tier 1 (Generic)	\$25 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	\$35 copayment	Copayment + charge over In-network allowed amount
Tier 3 (Brand)	\$50 copayment	Copayment + charge over In-network allowed amount
Tier 4 (Specialty Brand)	25% coinsurance	Coinsurance + charge over In-network allowed amount

There is \$50 per Drug Minimum and \$100 per Drug Maximum for each 30-day supply of Tier 4 Specialty Brand drugs.

Lens and Frame Coverage (BCBSNC will reimburse you up to the Benefit Period Maximum for glasses, hard, soft or disposable contact lenses.)

Prescribed Eyeglass Lens and Frame Reimbursement (per Benefit Period) \$200

¹ NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine the payment obligations for BCBSNC and its members.

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS FROM BCBSNC

Benefit Period

The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Allowed Amount

The charge that BCBSNC determines using a methodology that is applied to comparable providers for similar services under a similar health benefit plan.

Coinsurance Maximum

The dollar amount of coinsurance a member must pay prior to BCBSNC paying 100% for certain services. NOTE: In some plans, there is no coinsurance maximum; members are responsible for coinsurance once the deductible has been met.

Day and Visit Maximums

All day and visit maximums are on a combined In- and Out-of-Network basis.

Utilization Management

To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review and care management.

If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

Certification

Certification is a program designed to make sure that your care is given in a cost effective setting and efficient manner.

If you need to be hospitalized, you must obtain certification. Non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification from BCBSNC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your provider must request certification for coverage for additional days, which will be given by BCBSNC, if medically necessary.

All inpatient and outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health. Office visits do not require certification.

In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network provider. Obtaining certification for Mental Health and Substance Abuse services is the member's responsibility. Failure to obtain certification for Mental Health and Substance Abuse services will result in these services being paid at the out-of-network benefit level.

Health and Wellness Program

Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of HealthLine Blue, our 24-hour health information service, a health topics library, asthma and diabetes management and a prenatal program. You will also receive Active Blue, our health magazine and have access to online health and wellness information at www.bcsnc.com. With our program you can get health advice anytime you need it, so you can learn how to take charge of your health.

What Is Not Covered?

The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For hearing aids or tinnitus maskers
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means
- For self-injectable drugs in the provider's office

A waiting period for coverage of pre-existing conditions may apply to your coverage. BCBSNC defines pre-existing conditions as those conditions for which medical advice, diagnosis, care or treatment was received or recommended within 6 months of the date that your [BCBSNC] coverage begins. You may receive credit toward the 12-month waiting period if your enrollment date is within 63 days of the termination of your previous health coverage.

The benefit highlights is a summary of Blue Options benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are found in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from BCBSNC Customer Services.

CAMPUS HEALTH SERVICES

Please Remit: Completed form to Hill, Chesson & Woody
PO Box 3617
Chapel Hill, NC 27515-3617

CAMPUS HEALTH SERVICES APPLICATION FOR SERVICES

Applicant's Name _____
Last First MI

Mailing Address _____

PID _____ Telephone # _____ Birthdate ____/____/____

Department Name _____ Appointment Effective Date ____/____/____

I have attached the required information on my medical history.

REQUEST FOR OPTIONAL SPOUSAL COVERAGE

I request enrollment in the Campus Health Services Pre-Paid Health Care Plan for my spouse and certify that I am legally married to or a partner of _____

Applicant's Signature _____ Date _____

APPLICATION FOR SPOUSAL COVERAGE

Name _____
Last First MI

Mailing Address _____

PID _____ Telephone # _____ Birthdate ____/____/____

In addition to the premium for the BlueCross BlueShield of North Carolina Student Blue plan the monthly 2009-2010 health fee of \$44.50 is also required.

Applicant's Signature _____ Date _____



CAMPUS HEALTH SERVICES

James A. Taylor Building • The University of North Carolina at Chapel Hill • CB# 7470 • Chapel Hill, NC 27599-7470
Phone: 919-966-2281 Fax: 919-966-0616

Welcome to the University of North Carolina at Chapel Hill Campus Health Services (CHS) program. CHS provides comprehensive ambulatory health care and medical services. Please visit our website at http://campushealthservices.unc.edu for details regarding the scope of services and hours of operation. We look forward to serving you.

REPORT OF MEDICAL HISTORY POSTDOC AND POSTDOC SPOUSES Year: _____

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN NAME PERSONAL ID#(PID) DATE OF BIRTH (mo/day/yr)

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

GENDER: [] MALE [] FEMALE MARITAL STATUS: [] SINGLE [] MARRIED [] OTHER EMAIL _____

PREVIOUSLY ENROLLED HERE [] NO [] YES IF YES, DATES _____

UNC DEPARTMENT AFFILIATION: _____ [] POSTDOC [] POSTDOC SPOUSE

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY)** AREA CODE/TELEPHONE NUMBER
NAME OF POLICY HOLDER *SOCIAL SECURITY NUMBER EMPLOYER
POLICY OR CERTIFICATE NUMBER GROUP NUMBER **If you are enrolled in the BCBS of NC Student Medical Plan, your claims will be filed electronically for you. If not, you are responsible for filing your claims.

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

FAMILY & PERSONAL HEALTH HISTORY

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

Has any person, related by blood, had any of the following:

Table with 3 columns: Condition, Yes, No, Relationship. Rows include High blood pressure, Stroke, Heart attack before age 55, Blood or clotting disorder, Cholesterol or blood fat disorder, Diabetes, Glaucoma, Cancer (type), Alcohol/drug problems, Psychiatric illness, Suicide.

HEIGHT _____ WEIGHT _____

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

Large table with 4 columns: Condition, Yes, No, Year. Rows include High blood pressure, Rheumatic fever, Heart trouble, Pain or pressure in chest, Shortness of breath, Asthma, Pneumonia, Chronic cough, Head or neck radiation treatments, Tumor or cancer (specify), Malaria, Thyroid trouble, Diabetes, Serious skin disease, Mononucleosis, Hay fever, Allergy injection therapy, Arthritis, Concussion, Frequent or severe headache, Dizziness or fainting spells, Severe head injury, Paralysis, Disabling depression, Excessive worry or anxiety, Ulcer (duodenal or stomach), Intestinal trouble, Pilonidal cyst, Frequent vomiting, Gall bladder trouble or gallstones, Jaundice or hepatitis, Rectal disease, Severe or recurrent abdominal pain, Hernia, Easy fatigability, Anemia or Sickle Cell Anemia, Eye trouble besides need glasses, Bone, joint, or other deformity, Knee problems, Recurrent back pain, Neck injury, Back injury, Broken bone (specify), Kidney infection, Bladder infection, Kidney stones, Protein or blood in urine, Hearing loss, Sinusitis, Severe menstrual cramps, Irregular periods, Sexually trans. disease (STD), Blood transfusion, Alcohol use, Drug use, Anorexia/Bulimia, Smoke 1+ pack cigarettes/week, Regularly exercise, Wear seat belt, Other (specify).

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine			
Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

****INTERNATIONAL POSTDOCS/SPOUSES: International Postdocs/Spouses should have a TB skin test with negative (<5mm) within 12 months of employment.

		mo/day/year	mo/day/year	mo/day/year	mo/day/year
• Tuberculin (PPD) Test (within 12 months)	Date read mm induration				
Chest x-ray, if positive PPD	Date Results				
Treatment if applicable	Date				

IMPORTANT INFORMATION...PLEASE READ AND COMPLETE

STATEMENT BY POSTDOC/SPOUSE:

- (A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.
- (B) I hereby authorize any medical treatment for myself that may be advised or recommended by the physicians of the Campus Health Services.
- (C) I am aware that the Campus Health Services charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

Signature of Postdoc/Spouse

Date



THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

DIVISION OF STUDENT AFFAIRS

CAMPUS HEALTH SERVICES
JAMES A. TAYLOR BUILDING
CAMPUS BOX 7470
CHAPEL HILL, NC 27599-7470

July 6, 2009

<http://campushealth.unc.edu>

To Postdoctoral Workers and Spouses:

The staff at Campus Health Services welcomes you to Carolina. We look forward to assisting you with any health and wellness needs while you are here on campus.

This is just a reminder of the policy of Campus Health Services for all non-USA citizens and US citizens living abroad in all countries except for Western European countries and Australia/New Zealand who come to the University of North Carolina at Chapel Hill to provide the results of a skin test for tuberculosis skin test (TST). This policy is consistent with the guidelines from the Centers for Disease Control of the United States. If you have had a TST skin test within the last year, please send the result to Campus Health Services. Only TST tests that were performed in a United States facility and have a test result documented in millimeters of induration are considered valid.

If you can not provide the results of the TST, do not have a current TST (within the past year), or if your current test was not placed in a United States facility, please call 919-966-2281 and choose option 2 to schedule an appointment to get the test done at Campus Health Services within 60 days of employment. If you have any questions about this policy, please call 919-966-6573.

Sincerely,

Mary M. Covington, MD
Assistant Vice Chancellor for Campus Health Services

COMPLETE THIS FORM ONLY IF YOU ELECT TO WAIVE COVERAGE

**THE UNIVERSITY OF NORTH CAROLINA
AT CHAPEL HILL
POSTDOC MEDICAL INSURANCE PLAN**

WAIVER FORM

Name: _____
(Last) (First) (MI)

Social Security #: _____ Department: _____

I have reviewed the information on The University of North Carolina at Chapel Hill Blue Cross and Blue Shield Medical Insurance Plan provided for Temporary Full-Time Postdoctoral Trainees and Postdoctoral Research Associates.

I am aware that if the University supports my medical insurance financially, that amount is limited to no more than what is currently provided under the University's Supplemental Blue Cross and Blue Shield Medical Insurance Plan.

I hereby elect to waive coverage under the University's Blue Cross and Blue Shield Medical Insurance Plan and agree to maintain alternate coverage with the following carrier and notify my departmental manager at the University immediately if my coverage changes or is cancelled.

Please send one copy of this waiver form to Hill, Chesson & Woody and one copy to UNC Payroll Department.

Name of Medical Insurance Company: _____

Policy #: _____

Signature

Date