

Medical & Dental Add/Drop Form

Please return to: Postdoctoral Affairs, CCSR, Room 4235, 269 Campus Dr., Stanford, CA 94305-5173 or fax (650) 725-6106. This form can be completed online and then printed. (Signature required)

POSTDOCTORAL SCHOLAR INFORMATION:

Name: (First Last)	Stanford ID#:
Home Address:	E-mail:
Work Phone:	Home Phone:

DEPENDENT INFORMATION:

Circle all that apply (below):	Dependent Name: (First Last)	Date of Birth mm/dd/yy	Relationship	Primary Care Physician (only applicable if adding coverage for your dependent)
Medical Dental Add Drop				
Medical Dental Add Drop				
Medical Dental Add Drop				
Medical Dental Add Drop				

Does your single postdoctoral coverage remain active, yes or no? (circle, please)

Reason For Change:

Effective Date:

Signature:

Date:
