AMERICAN UNIVERSITY OF BEIRUT
BENEFITS COORDINATOR'S OFFICE

HEALTH INSURANCE PLAN
ENROLLMENT REQUEST AND AUTHORIZATION

I the undersigned hereby acknowledge that: I have received a copy of the Regulations of the Health Insurance Plan (HIP); and I am now fully familiar with its provisions. I hereby elect to participate in the HIP and authorize the University to deduct the monthly premium fee from my monthly compensation (Payroll). My membership continue automatically unchanged as long as I remain eligible under the Plan. No change in class or coverage is allowed unless I specifically request a change in writing, and then only in the following October. Any change in family status must be reported in writing within a maximum period of 21 days. After the lapse of 21 days, any change will be available if requested in writing during the following October.

EMPLOYEE NO	FAMILY NAME	FIRST NAME
DEPARTMENT	POSITION	EMPLOYMENT DATE

Membership coverage will be:

	1st Class	2nd Class
HIP	☐	☐
HIP/NSSF	☐	☐

REQUIRED COVERAGE	NAME	DATE OF BIRTH (DD/MM/YY)	SEX	STATUS		
				STUDENT	WORKING	NON WORKING
SUBSCRIBER						
SPOUSE						
1ST CHILD						
2ND CHILD						
3RD CHILD						
4TH CHILD						
5TH CHILD						
6TH CHILD						
7TH CHILD						
8TH CHILD						

OPTIONAL COVERAGE	NAME	DATE OF BIRTH (DD/MM/YY)	SEX	STUDENT	WORKING	NON WORKING
MATERNITY			F			
ADULT						
ADULT						
ADULT						

In the event you are a member of another Health Insurance Plan, please indicate the name of the Insurance Company _____.

EMPLOYEE'S SIGNATURE ---------- APPROVED ----------

DATE ---------- DATE ----------