FELLOWSHIP ACTIVATION

Current Date:	03/27/2024	Award Number:	105456		
Fellow's Name:	MANZO , GAETANO				
Award Period From:	08/29/2024	To:	08/28/2025	NED ID:	2003591881
Annual Stipend Amt:	$ 88,600.00			Daily:	$ 273.8889
-Outside Sponsor Amt:	$ 0.00			Monthly:	$ 8,216.67
+ Specialty Allowance:	$ 10,000.00			Advance Pymt Amt:	$ 0.00
= NIH Stipend Amt:	$ 98,600.00			Health Ins Reimb:	$ 0.00
-Annual Stipend Advance Adj:	$ 0.00	PROGRAM:	VF	WORK GROUP:	XG
=Annual Adj NIH Stipend amt:	$ 98,600.00		___ Activated		
Prorated NIH Stipend amt:	$ 98,600.00		_X_ Approved		

Check and Complete Appropriate Information:
___ New
_X_ Renewal (Provide Year, e.g. 1st, 2nd, etc.): _4 t_h
__ Transfer (Receiving IC) Old award number:
___ Final (Provide last permissible date in status): _____
___ Health Ins / Stp Change From: To:

Local Residential Mailing Address AND Tax Treaty Address for Visiting Fellows

4122 CHESAPEAKE STREET NW

Washington DC

In order to activate this award:

1. New fellows or those changing financial institution, complete the Automated Clearing House (ACH) Enrollment Form (SF-3881) for NIH to make stipend payments from the U.S. Treasury via Electronic Funds Transfer.

2. Health insurance information is attached. Please read the IMPORTANT notation on that form about coverage. After FAES signs the relevant sections, please return to the IC Approval Official listed below.

3. If you terminate your fellowship prior to the AWARD PERIOD TO above, we must be notified at least 8 weeks prior to your departure date. If received after this 8 week deadline, then you may be personally responsible for hand carrying the form through for clearance.

This is very important if a one-time advance stipend payment has been approved at the start of your fellowship since you will be personally liable for the overpayment.

4. Please verify the accuracy of the above information. If you concur, you and your sponsor must sign below, return a copy to the IC Approval Official, and retain a copy for your records. If your local address changes, please notify your IC Approval Official.

Fellowship Recipient's Signature

Fellowship Sponsor's Signature

Name of IC Approval Official : O A T I S , R O X A N N E
Bg., Rm., Phone : +1 301 5 9 43 6 5 9

ELECTION OF HEALTH INSURANCE (CHOICE 1)

To be Completed by NIH IC for Each Period of Award or Change of Coverage

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Name of IC Contact: O A T I S , R O X A N N E
NIH Address: Bg. Rm. Phone No.: +1 301 5 9 4 3 6 5 9

Name of FELLOW (Last, First, MI): MANZO , GAETANO
NIH Address: Bg. 38A Rm.10S101 5C Phone No.: +1 301 480 6441

IC/LAB/BR : NLM
AWARD NUMBER : 105456
PERIOD OF AWARD FROM : 08/29/2024 TO: 08/28/2025
FELLOWSHIP CATEGORY : FOREIGN ___ Activated
CAN: 8048021 _X_ Approved

Name of NIH SPONSOR: Augustin Luna
NIH Address: Bg. 38A Rm. 9N911 Phone No.: 3014354922

Check and Complete Appropriate Information:
___ New
_v__ Renewal (Provide Year, e.g. 1st, 2nd, etc.): _4 t h___
___ Transfer (Receiving IC) Old award number:
___ Final (Provide last permissible date in status): _____
___ Health Ins / Stp Change From: To:

To be completed by Fellow. IMPORTANT: Coverage with FAES must be finalized within thirty (30) days of activation of Fellow's NEW award. To be eligible, minimum award duration is generally at least 3 months and at least 32 hours/week in fellowship pay status. If not elected during this period, obtaining coverage with FAES may only be done during the annual FAES Open Season period (usually held in November of each year and will be effective in the following January).
** Please note that a health plan enrollment or change is neither ** required nor allowed with activation of a RENEWAL or TRANSFER. **

FAES: 10 CENTER DR, Rm 1N241 - MSC 1115

Insures: Individual X Family _ N/A _
Effective From Date:08/29/2024 Effective To Date:08/28/2025

By this election, I will consult with FAES on my election and will complete the documents in this office. This is to authorize NIH to make monthly premium payments to FAES on my behalf. NIH is responsible for the payment of premiums to FAES. Questions regarding the extent of coverage, claims, etc., are a matter to be resolved by the fellow through the FAES and the insurance carrier.

Name of IC Approval Official : O A T I S , R O X A N N E
Bg., Rm., Phone : +1 301 5 9 4 3 6 5 9

ELECTION OF HEALTH INSURANCE (CHOICE 1 CONTINUATION)

To be Completed by FAES in 10 CENTER DR Rm 1N241 - MSC 1115

Signature of FAES Insurance Representative: _____

Effective Date of Insurance: _____

Total Monthly Premium: $ 713.00

SIGNATURE OF FELLOW: _____ DATE: 03/27/2024

My signature attests that the information provided above is accurate And that I will notify the IC Contact of any change in status.

PRIVACY ACT INFORMATION - This information is authorized for collection under Section 301 of the Public Health Service Act, as amended. NIH requires that all fellows have health insurance coverage, either in their own name or as a 'family member'. This information will be used by NIH to assure compliance with the policy and to disburse funds to you or FAES. Failure to provide this information may result in the cancellation of your fellowship award.

Name of IC Approval Official: O A T I S , R O X A N N E

Bg., Rm., Phone: +1 301 5 9 4 3 6 5 9