

COLUMBIA UNIVERSITY MEDICAL CENTER CAMPUS
PETITION TO ADD/DROP STUDENT AND/OR DEPENDENT 2010-2011

Due to Birth, Adoption, Marriage, Expiration of Parental Insurance or any other Life Change Event

1. Complete all student information

Enrolled Student Name: _____
Last Name First Name MI

Student ID Number or UNI # _____ Date of Birth _____ Gender: Male Female

Email address: _____

School of Registration: _____

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ phone Number: _____

2. Reason for Petition at this time: (MUST WRITE REASON FOR PETITION. DOCUMENTATION IS REQUIRED.)

Select enrollment period: Must enroll in SHS in order to enroll in AETNA Student Health (check One)

Student Health Service:

- Individual
- Student/Spouse/Domestic partner

AETNA Student Health (check One)

- Student Only
- Student & Spouse/Domestic partner
- Student & Child (ren)
- Student & Spouse/Child (ren)

Effective Date: _____

Termination Date: 8/16/2011

COMPLETE SECTION 3 ONLY IF ENROLLING DEPENDENTS

List dependents to be insured. Dependent coverage is only available if the student is covered.

Dependents	Last Name	First Name	DOB	Gender
Spouse/ domestic partner	_____	_____	_____	_____
Child	_____	_____	_____	_____
Child	_____	_____	_____	_____

Notice to student (signature required)

I have carefully read the brochure and elect to enroll as indicated. Rates are not prorated other than as listed. I permit Columbia University to provide AETNA Student Health/The Chickering Group with my enrollment status for purpose of eligibility under this Plan. I warrant that the information I have provided on this Application form is true and I am aware that if I provide false information, my coverage and my dependent(s) coverage can be made void. I understand that if it is later determined that the student is not eligible, the premium will be refunded, unless a claim has been filed, but the premium is not refundable for reasons other than eligibility.

Student's Signature: _____ *Date:* _____

Administrative use only

Method of payment: (circle one) Student Account; check; Cash; Money Order, SIS/SSOL

Amount Paid: \$ _____

MAIL TO: Dilenny De La Cruz, Student Health Service, 630 West 168th Street, Box 77, New York, NY 10032
FAX: 212-342-3947 • Phone: 212-342-3944 • Website: www.cumc.columbia.edu/student/health
Ms. Dilenny De La Cruz E-mail Address: dd2184@columbia.edu