



Mail: 630 W. 168<sup>th</sup> Street, Mailbox 77, NY, NY 10032  
 Location: 60 Haven Avenue, NY, NY 10032 – Tel. 212-305-3400 – Fax 212-342-3955

**Part-time Student & Approved Leave Enrollment Application 2009-10  
 Student Health Service & Aetna Student Health Insurance Plan**

**1. COMPLETE ALL STUDENT INFORMATION.**

Enrolled Student Name: \_\_\_\_\_  
Last Name First Name MI

C #: \_\_\_\_\_ Uni ID \_\_\_\_\_ School \_\_\_\_\_ Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street & Apt. # City & State Zip Code

Phone Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female  
mm/dd/yyyy

Student applying for coverage for an approved leave must submit the Dean's Verification Form for approved leave (available at [www.cumc.columbia.edu/student/health](http://www.cumc.columbia.edu/student/health)). Click on forms.

**2. SELECT ENROLLMENT PERIOD:**

**(New Students Only)**

**Annual: 8-17-\_\_\_\_\_ to 8-16-\_\_\_\_\_**      **Spring: 1-15-\_\_\_\_\_ to 8-16-\_\_\_\_\_**      **Summer: 6-01-\_\_\_\_\_ to 8-16-\_\_\_\_\_**  
**Enrollment Deadline: 9-30-\_\_\_\_\_**      **Enrollment Deadline: 2-28 \_\_\_\_\_**      **Enrollment Deadline: 6-30 \_\_\_\_\_**

**Student Health Service:**

	<b>Annual 8/17/09-8/16/10 Deadline: 9/30/09</b>	<b>Spring 1/15-10 – 8/16/10 Deadline: 2/28/10</b>	<b>Summer 6/01/10 – 8/16/10 Deadline: 6/30/10</b>
1. Individual	<input type="checkbox"/> <b>\$1,025.00</b>	<input type="checkbox"/> <b>\$598.00</b>	<input type="checkbox"/> <b>\$214.00</b>

**Chickering/Aetna Insurance**

	<b>Annual 8/17/09-8/16/10 Deadline: 9/30/09</b>	<b>Spring 1/15/10 – 8/16/10 Deadline: 2/28/10</b>	<b>Summer 6/01/10 – 8/16/10 Deadline: 6/30/10</b>
1. Individual	<input type="checkbox"/> <b>\$2858.00</b>	<input type="checkbox"/> <b>\$1667.00</b>	<input type="checkbox"/> <b>\$595.00</b>

**3. 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 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ADMINISTRATIVE USE ONLY:**

Charge Student Account: \_\_\_\_\_ Date: \_\_\_\_\_  
 Batch #/Topper: \_\_\_\_\_ Date: \_\_\_\_\_  
 Transferred to Aetna (FTP) \_\_\_\_\_ Date: \_\_\_\_\_  
 Entered into Pyramed/EHR \_\_\_\_\_ Date: \_\_\_\_\_

**Mail or Fax to Eladia Goris**  
**MAIL: Student Health Service – CUMC, 630 W. 168<sup>th</sup> St., Box 77, NY, NY 10032**      **FAX 212-342-3947**