

**2024-2025 Enrollment Application
 Student Health on Haven & Aetna Student Health Insurance Plan**

Enrollment Periods:
Fall Semester: 08/01/2024-09/30/2024
Spring Semester: 01/01/2025-02/15/2025 (New Students Only)
Summer Semester: 05/15/2025-06/30/2025 (New Students Only)
Please Complete all Information:

 Student's Name: _____
Last Name
First Name
MI

Columbia PID or C Number: _____ CU Email address: _____ School of Registration: _____

 Date of Birth: _____ Sex Assigned at Birth: Male Female Phone Number: _____

Mailing Address: _____

City: _____ State _____ Zip Code: _____

Please Select Enrollment Type: Part-Time Student Adding Dependents Approved Leave of Absence

Student applying for coverage for an approved leave must submit the Dean's Verification Form & coverage is limited to two semesters.

For timely processing, please send supporting documentation (ie. Marriage license, birth certificate)

<p><u>Student Health on Haven</u></p> <input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse/Domestic Partner <input type="checkbox"/> Individual & Child 18 & over <input type="checkbox"/> Individual Spouse Child 18 & over	<p><u>Aetna Student Health Insurance</u></p> <input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse/Domestic Partner <input type="checkbox"/> Individual & Child <input type="checkbox"/> Individual & 2 or More Children <input type="checkbox"/> Individual & Spouse & 1Child <input type="checkbox"/> Individual & Spouse & 2 or More Children
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Dependent Information:	Last Name	First Name	DOB	Sex Assigned at Birth	Dependent E-Mail	Dependent Phone No.
Spouse/Domestic Partner						
Child						
Child						
Child						

Annual Coverage for a student and spouse on the Aetna Student Health Insurance Plan and the Student Health on Haven costs (\$4,955+ \$1,656) + (\$4,955+ \$1,656) = \$13,222

For semester breakdown please visit the [Student Health on Haven Fees](#) page.

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 insurance 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: _____