



STUDENT HEALTH ON HAVEN

2024-25 Life Change Event Form

You have 60 days from the date of your Life Change Event to notify our office. For timely processing in addition to this form, please send supporting documentation (ie. insurance effective or termination letter).

1. Please Complete all Student 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:

2. Please Select Enrollment type:

Adding AETNA Insurance: Health & Related Services Fee is mandatory for all students enrolled in AETNA.
Effective Date: Termination Date: 8/14/2025
Dropping AETNA Insurance: If you have any paid Medical or Rx claims this waiver will be denied.
Effective Date:

3. Reason for Life Change Event at this time:

4. Please complete this section if you have dependents:

Adding Coverage Dropping Coverage
Effective Date: Termination Date: 8/14/2025 Effective Date:

5. List dependents to be insured: Dependent coverage is only available if the student is covered. Please note: All dependents 18 and over must also enroll in the Health & Related Services Fee. If enrolling dependents, submit supporting verification such as marriage license for spouse, birth certificate for children etc.

Table with 7 columns: Last Name, First Name, DOB, Sex Assigned at Birth, Dependent E-Mail, Dependent Phone No. Rows include Spouse/Domestic Partner, Child, 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 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:

EMAIL FORM TO: shsinsurance@cumc.columbia.edu or FAX: 212-342-3947
Location: 100 Haven Avenue Suite 230, NY, NY 10032
Website: www.studenthealth.cuimc.columbia.edu