2018-2019 HEALTH INSURANCE ENROLLMENT FORM

	ANNUAL 08/15/18-08/14/19	SPRING SEMESTER ONLY 1/1/19-08/14/2019
STUDENT ONLY	$3,104.00*	$ 1,968.00*
ONE DEPENDENT (ADDITIONAL)	$3,054.00	$ 1,918.00
TWO DEPENDENTS (ADDITIONAL)	$6,108.00	$ 3,836.00
FAMILY (3+ DEP) (ADDITIONAL)	$9,162.00	$ 5,754.00

***Includes $50 student admin fee**

LAST NAME ______________________________________ **FIRST NAME:** _____________________________________ **MI** __________

DATE OF BIRTH: ______________________ **STUDENT ID#:** _______________________________ **GENDER:** MALE **or** FEMALE

SOCIAL SECURITY #: ____________/__________/____________ **UCONN Email:** ____

U.S. ADDRESS:____

CITY:____**STATE:**________________ **ZIP** _________________

CAMPUS: **UCONN/**STORRS **UCONN/**REGIONAL **STATUS:** GRAD-STUDENT UNDERGRAD-STUDENT

REGISTRATION:_______ # CREDITS **HOME/CELL PHONE**: _________________________________

UCONN HEALTH- ONLY/ SCHOOL OF: **DENTAL** **OR** **MEDICINE**

Enter Dependent Information Here:

SPOUSE:

LAST NAME: ____ FIRST NAME: _________________________________ MI_____

DATE OF BIRTH: ____________________SSN# ________________________ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: ____ FIRST NAME: _________________________________ MI_____

DATE OF BIRTH: ____________________SSN# ________________________ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: ____ FIRST NAME: _________________________________ MI_____

DATE OF BIRTH: ____________________SSN# ________________________ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: ____ FIRST NAME: _________________________________ MI_____

DATE OF BIRTH: ____________________SSN# ________________________ GENDER: MALE FEMALE

CONTINUED ON THE BACK

DEPENDENT CHILD

LAST NAME: ______________________________________ FIRST NAME: ______________________________ MI_____

DATE OF BIRTH: ___________________SSN# ______________________ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: ______________________________________ FIRST NAME: ______________________________ MI_____

DATE OF BIRTH: ___________________SSN# ______________________ GENDER: MALE FEMALE

Acknowledgements:
By my signature here:

I acknowledge that I have reviewed the coverage available under the Student Health Insurance Plan offered by the University of Connecticut through Consolidated Health Plans (CHP)/Cigna.
I acknowledge that once enrolled I will be unable to request cancellation of this coverage and once enrolled the coverage will remain in effect until the expiration date of the current year policy period, August 14, 2019. (Exception: Students entering military services are allow a prorated cancellation.)
I acknowledge and accept all of the above and request enrollment in the UCONN Student Health Insurance Plan.

____ __________________________________

STUDENT SIGNATURE **DATE**

PLEASE MAIL PAYMENTS TO:
BAILEY AGENCIES, A DIVISION OF SMITH BROTHERS INSURANCE
377 MAIN STREET, SUITE 103, NIANTIC CT 06357

MAKE CHECKS PAYABLE TO:
SMTH BROTHERS INSURANCE LLC

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AGENCY USE ONLY

- ☐ Sent Enrollment to Carrier
- ☐ Confirmed by Carrier
- ☐ Invoiced
- ☐ Sent Temporary ID card
- ☐ Logged Excel List- Master
- ☐ Logged Excel Flow Report
- ☐ Logged Excel Acct Report

Notes: ____

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