UCONN
UNIVERSITY OF CONNECTICUT

2019-2020 HEALTH INSURANCE ENROLLMENT FORM

	ANNUAL 08/15/2019 - 08/14/2020	SPRING SEMESTER ONLY 1/1/2020 - 08/14/2020
STUDENT ONLY	**$2,795.00***	**$ 1,752.00***
ONE DEPENDENT (ADDITIONAL)	**$2,745.00**	**$ 1,702.00**
TWO DEPENDENTS (ADDITIONAL)	**$5,490.00**	**$ 3,404.00**
FAMILY (3+ DEP) (ADDITIONAL)	**$8,235.00**	**$ 5,106.00**

***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

CURRENT 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 through the University of Connecticut by Wellfleet Insurance.

I acknowledge that once enrolled I will be unable to request cancellation of this coverage and the coverage will remain in effect until the expiration date of the current year policy period, August 14, 2020. (Exception: Students entering military services are allow a prorated cancellation.)

I acknowledge and accept all the above and request enrollment in the UCONN Student Health Insurance Plan.

_____ _____

STUDENT SIGNATURE **DATE**

PLEASE MAIL PAYMENTS TO:
SMITH BROTHERS INSURANCE
377 MAIN STREET, SUITE 103, NIANTIC CT 06357

MAKE CHECKS PAYABLE TO:
SMITH BROTHERS INSURANCE LLC

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AGENCY USE ONLY

☐ Sent Enrollment to Carrier ☐ Logged Master Report

☐ Confirmed by Carrier ☐ Logged Flow Report

☐ Invoiced ☐ Logged Agency Report

☐ Sent Temporary ID card

Notes: _____

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