UCONN
UNIVERSITY OF CONNECTICUT

2020-2021 HEALTH INSURANCE ENROLLMENT FORM

	FULL POLICY YEAR 08/15– 7/31	FALL ONLY 08/15-12/31	SPRING ONLY/NEW 01/01-07/31	SPRING/CONT 01/01-07/31
STUDENT ONLY	$2,835.00*	$1,153.00*	$1,732.00*	$1,682.00
ADD-ONE DEPENDENT	$2,784.00	$1,103.00	$1,682.00	$1,682.00
ADD-TWO DEPEENDENT	$5,570.00	$2,206.00	$3,364.00	$3364.00
ADD- 3+ DEPENDENTS	$8,355.00	$3,309.00	$5,046.00	$5,046.00

*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 U-GRAD MEDICAL / DENTAL / Med. or Dent. RESIDENT

FULL TIME: YES OR NO _____ # CREDITS CURRENT REGISTRATION (CLASS ROOM ONLY**)**

HOME/CELL PHONE: _____

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

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, July 31, 2021. (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 Confirmation

Notes: _____

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