UCONN
UNIVERSITY OF CONNECTICUT

2021-2022 HEALTH INSURANCE ENROLLMENT FORM

	FULL POLICY YEAR 08/01– 7/31	SPRING ONLY/NEW 01/01-07/31	SPRING/CONT 01/01-07/31
STUDENT ONLY	$2,946.00*	$1,733.00*	$1,683.00
ADD-ONE DEPENDENT	$2,896.00	$1,683.00	$1,683.00
ADD-TWO DEPEENDENT	$5,792.00	$3,366.00	$3,366.00
ADD- 3+ DEPENDENTS	$8,688.00	$5,049.00	$5,049.00

*Includes $50 student admin fee

LAST NAME _____**FIRST NAME:** _____ **MI** _____

DATE OF BIRTH: _____ **UCONN NetID#:** _____ **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 2021-2022 PY 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, 2022. (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 To Student, Date:_____

Notes: _____

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