Teachers College: Phone (212) 678-3006
Union Theological Seminary: Phone (212) 280-1396
Jewish Theological Seminary: Phone (212) 678-8014

Enrollment Form for Columbia Health Fee 2016-17

Student's Name: ____

PID/UNI: ____

School Attending: ____

Semester: ____

Number of Credits: ____

Columbia E-Mail Address: ____

Please enroll me in Columbia Health for the following semester

☐ Fall 2016	08/15/16 – 12/31/16	$510
☐ Spring 2017	01/01/17 – 08/14/17	$510

By signing below, I authorize Columbia Health to bill my student account at the rate(s) indicated above.

I understand that the Columbia Health fee provides access to on campus care only. I accept responsibility for any additional fees incurred such as prescriptions, laboratory, radiology (x-ray) testing and outside medical consultations.

I am aware that it is my responsibility to submit claims for additional charges to my insurance carrier. I understand that the fee is **non-refundable once this form is processed.**

Signature:____ Date________________

Received by CH Staff:__________________________________ Date________________
Please Print Name

COMMENTS:____

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FOR OFFICE USE ONLY:

Processed by ______________________________________ **Date:**____________________