



Teachers College: Phone (212) 678-3006
Union Theological Seminary: Phone (212) 280-1396
Jewish Theological Seminary: Phone (212) 678-8007

Enrollment Form for Columbia Health Fee 2017-18

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

<input type="checkbox"/> Fall 2017	08/15/17 - 12/31/17	\$541
<input type="checkbox"/> Spring 2018	01/01/18 - 08/14/18	\$541

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 Staff: _____ Date _____

Please Print Name

COMMENTS: _____

FOR OFFICE USE ONLY:

Processed by _____ Date: _____