COLUMBIA HEALTH

Morningside Campus
2018-19 Dependent Enrollment Application
Aetna Student Health Insurance Plan

Enrollment Periods: **Fall: 07/15/2018-09/30/2018 Spring*: 12/15/2018-02/15/2019 Summer*: 05/01/2019-06/30/2019**

The 90 Plan	Fall Premium 8/15/18-12/31/18	Spring Premium 1/1/19-8/14/19	Annual Premium 8/15/18-8/14/19	Summer Premium 5/15/19-8/14/19
Student & Spouse/Domestic Partner(DP)**	$2,444	$3,976	$6,420	$1,626
Student & 1 Child	$2,433	$3,958	$6,391	$1,615
Student & 2+ Children	$3,644	$5,928	$9,572	$2,417
Student & Spouse/DP** & 1 Child	$3,655	$5,946	$9,601	$2,428
Student & Spouse/DP** & 2+ Children	$4,866	$7,916	$12,782	$3,230
The 100 Plan				
Student & Spouse/Domestic Partner(DP)**	$3,254	$5,286	$8,540	$2,166
Student & 1 Child	$3,235	$5,257	$8,492	$2,147
Student & 2+ Children	$4,843	$7,871	$12,714	$3,211
Student & Spouse/DP** & 1 Child	$4,862	$7,900	$12,762	$3,230
Student & Spouse/DP** & 2+ Children	$6,470	$10,514	$16,984	$4,294

***New incoming students only.**
****Fall/Spring - Spouse/Domestic Partners are billed an additional $281 per semester Columbia Health Fee.**
New incoming Summer Students - Spouse/Domestic Partners are billed an additional TBD Columbia Health Fee.
All dependents are enrolled on the same plan as the student. Enrollment is for the full plan year as long as the student remains registered for the Fall and Spring terms.
Rates listed above are inclusive of the student premiums and are billed to the student account when you register in the respective term.

Please complete all information:

Student's name: _____
Last Name **First Name** **MI**

Mailing Address:_____

Columbia UNI: _____ CU Email address: _____

School of Registration: _____ Date of Birth: _____ Gender ☐ Male ☐ Female

DEPENDENT INFORMATION:

	Last Name	First Name	DOB (MM/DD/YYYY)	Gender	Phone No. or Email
Spouse/ Domestic Partner					
Child					
Child					
Child					

☐ I permit Columbia University to provide Aetna Student Health Insurance with my enrollment status for purpose of eligibility under this Plan. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage and my dependent(s) coverage can be made void. I understand that if it is later determined that the student is not eligible; the premium will be refunded, unless a claim has been filed, but the premium is not refundable for reasons other than eligibility.

☐ I certify my understanding that most off-campus non-emergency medical care requires a referral from Columbia Health Medical Services prior to my spouse/domestic partner's appointments; referrals are not required for dependent mental health services. Failure to obtain a referral in advance will result in significant additional out of pocket costs, for which I accept full fiscal responsibility. Dependent children do not require referrals.

Signature _____ Date: _____

Received:

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