COLUMBIA HEALTH

2024 – 2025 Columbia Health and Related Services Enrollment Form

Student's Name: ______________________________

PID/UNI: ______________________________

School Attending: ______________________________

Columbia E-mail Address: ______________________________

☐ Please enroll me in the Columbia Health and Related Services Program for the 2024-2025 plan year.

Plan Year:

Fall 2024	08/15/24 – 12/31/24	$694
Spring 2025	01/01/25 – 8/14/25	$694

By signing below, I authorize Columbia Health to bill my student account, each semester, at the rate indicated above. Coverage will continue into the spring term as long as I remain a registered student.

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: ____________________

Please email the completed form to studentinsurance@columbia.edu for processing.