COLUMBIA | COLUMBIA UNIVERSITY IRVING MEDICAL CENTER
STUDENT HEALTH ON HAVEN

2023-2024 Enrollment Application
Student Health on Haven & Aetna Student Health Insurance Plan

Enrollment Periods:

Fall Semester: 08/01/2023-09/30/2023
Spring Semester: 01/01/2024-02/15/2024 (New Students Only)
Summer Semester: 05/15/2024-06/30/2024 (New Students Only)

Please Complete all Information:

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

Columbia PID or C Number: _____ CU Email address: _____ School of Registration: _____

Date of Birth: _____ Sex Assigned at Birth: ☐ Male ☐ Female Phone Number: _____

Mailing Address: _____

City: _____ State _____ Zip Code: _____

Please Select Enrollment Type: ☐ Part-Time Student ☐ Adding Dependents ☐ Approved Leave of Absence

Student applying for coverage for an approved leave must submit the Dean's Verification Form & coverage is limited to two semesters.
For timely processing, please send supporting documentation (ie. Marriage license, birth certificate)

Student Health on Haven	**Aetna Student Health Insurance**
☐ Individual	☐ Individual
☐ Individual & Spouse/Domestic Partner	☐ Individual & Spouse/Domestic Partner
☐ Individual & Child 18 & over	☐ Individual & Child
☐ Individual Spouse Child 18 & over	☐ Individual & 2 or More Children
	☐ Individual & Spouse & 1Child
	☐ Individual & Spouse & 2 or More Children

Dependent Information:	**Last Name**	**First Name**	**DOB**	**Sex Assigned at Birth**	**Dependent E-Mail**	**Dependent Phone No.**
Spouse/Domestic Partner						
Child						
Child						
Child						

Annual Coverage for a student and spouse on the Aetna Student Health Insurance Plan and the Student Health on Haven costs ($4,541+ $1,624) + ($4,541+ $1,624) = $12,330

For semester breakdown please visit the Student Health on Haven Fees page.

I have carefully read the brochure and elect to enroll as indicated. Rates are not prorated other than as listed. 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.

Signature_____Date: _____

EMAIL FORM TO: shsinsurance@cumc.columbia.edu or FAX: 212-342-3947
Location: 100 Haven Avenue Suite 230, NY, NY 10032
Website: https://www.studenthealth.cuimc.columbia.edu/