COLUMBIA | COLUMBIA UNIVERSITY IRVING MEDICAL CENTER

STUDENT HEALTH ON HAVEN

2024-25 Life Change Event Form

You have 60 days from the date of your Life Change Event to notify our office. For timely processing in addition to this form, please send supporting documentation (ie. insurance effective or termination letter). You will be billed for insurance retroactively to the date you lost coverage.

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1. Please Complete all Student 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: _____

2. Please Select Enrollment type:

☐ Adding AETNA Insurance: **Health & Related Services Fee is mandatory for all students enrolled in AETNA. You will be billed for insurance retroactively to the date you lost coverage.**

Effective Date: _____ Termination Date: 8/14/2025

☐ Dropping AETNA Insurance: **If you have any paid Medical or Rx claims this waiver will be denied.**

Effective Date: _____

3. Reason for Life Change Event at this time: _____

4. Please complete this section if you have dependents: You will be billed for your dependent's insurance retroactively to the date they lost coverage.

☐ Adding Coverage ☐ Dropping Coverage

Effective Date: _____ Termination Date: 8/14/2025 Effective Date: _____

List dependents to be insured: *Dependent coverage is only available if the student is covered. Please note: All dependents 18 and over must also enroll in the Health & Related Services Fee. If enrolling dependents, submit supporting verification such as marriage license for spouse, birth certificate for children etc. You will be billed for your dependent's insurance retroactively to the date they lost coverage.*

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

Notice to student (signature required):

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 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.

Student's Signature: _____ _____ Date: _____

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