



STUDENT HEALTH ON HAVEN

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.

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: _____

☐ 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: 8/14/2026

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

Effective Date: _____

☐ Adding Coverage
 ☐ Dropping Coverage
 Effective Date: _____ Termination Date: 8/14/2026 Effective Date: _____

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

Student's Signature: _____ Date: _____

Website: www.studenthealth.cuimc.columbia.edu