

**Enrollment Form for Health Service Program 2007-08**

Student's Name: \_\_\_\_\_

PID/UNI: \_\_\_\_\_

School Attending: \_\_\_\_\_

Semester: \_\_\_\_\_

Number of Credits: \_\_\_\_\_

Columbia E-Mail Address: \_\_\_\_\_

**Please enroll me for the Health Service fee for the following semester**

<input type="checkbox"/> Fall 2007	09/01/07 - 01/21/08	\$387
<input type="checkbox"/> Spring 2008	01/22/08 - 08/31/08	\$387

By signing below, I authorize Health Services at Columbia to bill my student account at the rate(s) indicated above.

I understand that the Health Service Fee does NOT provide insurance coverage. 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 \_\_\_\_\_

Received by HS Staff: \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FOR OFFICE USE ONLY:**

Processed by \_\_\_\_\_ Date: \_\_\_\_\_