COLUMBIA HEALTH

2023-2024 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 2023-2024 plan year**

Fall 2023	08/15/23 – 12/31/23	$682
Spring 2024	01/01/24 – 8/14/24	$682

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.