COLUMBIA HEALTH

2025 Summer 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 summer 2025 term.**

Summer 2025	05/15/25 – 8/14/25	$500

By signing below, I authorize Columbia Health to bill my student account for the summer term, at the rate indicated above.

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.**

Please note, this form is only for new incoming summer students. Students registered for the spring 2025 term must pay the Spring Health and Related Service Fee.

Signature: _____ Date_____

Please email the completed form to studentinsurance@columbia.edu for processing.