COLUMBIA HEALTH

2025 -2026 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 2025 -2026 plan year.**

Fall 2025	08/15/25 – 12/31/25	$723
Spring 2026	01/01/26 – 08/14/26	$723

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