



## 2026 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 2026 term.

Summer 2026	05/15/26 - 8/14/26	\$520
-------------	--------------------	-------

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 2026 term must pay the Spring Health and Related Service Fee.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Please email the completed form to [studentinsurance@columbia.edu](mailto:studentinsurance@columbia.edu) for processing.