UCONN
UNIVERSITY OF CONNECTICUT

2019-2020 HEALTH INSURANCE PRO-RATED ENROLLMENT FORM-VISITING SCHOLARS-SHORT TERM

Effective Date: _____

STUDENT ONLY: **$232.50** x _____ **# of months needed = $** _____
(minimum 1 month)
ONE DEPENDENT: **$232.50** x _____ **# of months needed = $** _____
(ADDITIONAL TO STUDENT)
TWO DEPENDENTS: **$465.00** x _____ **# of months needed = $** _____
(ADDITIONAL TO STUDENT))
FAMILY (3+ DEP): **$697.50** x _____ **# of months needed = $** _____ **Total Payable ALL:**_____
(ADDITIONAL TO STUDENT)

LAST NAME _____**FIRST NAME:** _____ **MI** _____

DATE OF BIRTH: _____ **STUDENT ID#:** _____ **GENDER:** MALE **or** FEMALE

SOCIAL SECURITY #: _____/_____/_____ **(IF APPICABLE)**

U.S. ADDRESS:_____

CITY:_____**STATE:**_____ **ZIP** _____

CAMPUS: **UCONN/**STORRS **UCONN/**REGIONAL **PERSONAL PHONE:** _____

UCONN Email: _____ **UCONN DEPARTMENT PHONE:** _____

Enter Dependent Information Here:

SPOUSE:

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

CONTINUED ON THE BACK

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

Acknowledgements:
By my signature here:

I acknowledge that I have reviewed the coverage available under the Student Health Insurance Plan offered through the University of Connecticut by Wellfleet Insurance.

I acknowledge that once enrolled I will be unable to request cancellation of this coverage and the coverage will remain in effect until the expiration date of the requested enrollment period noted on this form.

I acknowledge and accept all of the above and request enrollment in the UCONN Student Health Insurance Plan.

_____ _____

STUDENT SIGNATURE **DATE**

PLEASE MAIL PAYMENTS TO:
SMITH BROTHERS INSURANCE
377 MAIN STREET, SUITE 103, NIANTIC CT 06357

MAKE CHECKS PAYABLE TO: SMITH BROTHERS INSURANCE LLC

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AGENCY USE ONLY

☐ Sent Enrollment to Carrier ☐ Logged Master Report

☐ Confirmed by Carrier ☐ Logged Flow Report

☐ Invoiced ☐ Logged Agency Report

☐ Sent Temporary ID card

Notes: _____

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