2021-2022 HEALTH INSURANCE PRO-RATED ENROLLMENT FORM-VISITING SCHOLARS-SHORT TERM

Effective Date:

STUDENT ONLY: **$246.00** **x ______** **# of months needed** **= $ __________**
(minimum 1 month)
ONE DEPENDENT: **$246.00** **x ______** **# of months needed** **= $ __________**
(ADDITIONAL TO STUDENT)
TWO DEPENDENTS: **$492.00** **x ______** **# of months needed** **= $ __________**
(ADDITIONAL TO STUDENT))
FAMILY (3+ DEP): **$738.00** **x ______** **# of months needed** **= $ __________** **Total Payable ALL: $___________**
(ADDITIONAL TO STUDENT)

LAST NAME ___________________________________**FIRST NAME:** ___________________________________ **MI** __________

DATE OF BIRTH: _______________________ **UCONN NetID#:** _____________________________ **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 2021-2022 PY 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
- ☐ Confirmed by Carrier
- ☐ Invoiced
- ☐ Sent Confirmation to Student, Date: ______________
- ☐ Logged Master Report
- ☐ Logged Flow Report
- ☐ Logged Agency Report

Notes: ____

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