



2023-2024 HEALTH INSURANCE ENROLLMENT FORM

FULL POLICY YEAR
08/01- 7/31

Table with 2 columns: Insurance Category (STUDENT ONLY, ADD-ONE DEPENDENT, ADD-TWO DEPENDENT, ADD- 3+ DEPENDENTS) and Cost (\$3,190.00\*, \$3,140.00, \$6,280.00, \$9,420.00)

\*Includes \$50 student admin fee

LAST NAME FIRST NAME: MI

DATE OF BIRTH: UCONN NetID#: GENDER: MALE or FEMALE

SOCIAL SECURITY #: UCONN Email:

U.S. ADDRESS:

CITY: STATE: ZIP:

CAMPUS: UCONN/STORRS UCONN/REGIONAL STUDENT STATUS: U-GRAD GRAD MEDICAL DENTAL MED/DENT RESIDENT

FULL TIME: YES OR NO # CREDITS CURRENT REGISTRATION (CLASSROOM ONLY)

HOME/CELL 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

**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 2023-2024 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 current year policy period, July 31, 2024. (Exception: Students entering military services are allow a prorated cancellation.)

I acknowledge and accept all 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, NIAN TIC CT 06357

**MAKE CHECKS PAYABLE TO:**  
 SMITH BROTHERS INSURANCE LLC

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**AGENCY USE ONLY**

- |  |   |
|--|---|
| <input type="checkbox"/> Sent Enrollment to Carrier                | <input type="checkbox"/> Logged Master Report |
| <input type="checkbox"/> Confirmed by Carrier                      | <input type="checkbox"/> Logged Flow Report   |
| <input type="checkbox"/> Invoiced                                  | <input type="checkbox"/> Logged Agency Report |
| <input type="checkbox"/> Sent Confirmation To Student, Date: _____ |   |

Notes: \_\_\_\_\_

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