UCONN
UNIVERSITY OF CONNECTICUT

# 2025-2026 HEALTH INSURANCE ENROLLMENT FORM- FALL-ANNUAL

**FULL POLICY YEAR**
**08/01– 7/31**

| | |
|---|---|
| **STUDENT ONLY** | **$3,214.00*** |
| **ADD-ONE DEPENDENT** | **$3,144.00** |
| **ADD-TWO DEPEENDENT** | **$6,288.00** |
| **ADD- 3+ DEPENDENTS** | **$9,432.00** |

***Includes $70 student admin fee**

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

**DATE OF BIRTH (MM/DD/YYYY):** _____ **UCONN NetID#:** _____ **SEX:** M F U

**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 (MM/DD/YYYY): _____SSN# _____ SEX: M F U

**DEPENDENT CHILD**

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH (MM/DD/YYYY): _____SSN# _____ SEX: M F U

**DEPENDENT CHILD**

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH (MM/DD/YYYY): _____SSN# _____ SEX: M F U

**DEPENDENT CHILD**

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH (MM/DD/YYYY): _____SSN# _____ SEX: M F U

**DEPENDENT CHILD**

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH (MM/DD/YYYY): _____SSN# _____ SEX: M F U

**DEPENDENT CHILD**

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH (MM/DD/YYYY): _____SSN# _____ SEX: M F U

**Acknowledgements:**
By my signature here:

I acknowledge that I have reviewed the coverage available under the 2025-2026 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, 2026. (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, 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/ Item#: _____

☐ Sent Confirmation to Student, Date: _____

☐ Logged Master Report

☐ Logged Flow Report

☐ Logged Agency Report

☐ Report to: Marina B- Accts Rec.

Notes: _____

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