UCONN
UNIVERSITY OF CONNECTICUT

2025-2026 HEALTH INSURANCE ENROLLMENT FORM-SPRING

SPRING ONLY/NEW
01/01 - 07/31

STUDENT ONLY	**$1,897.00***
ADD-ONE DEPENDENT	**$1,827.00**
ADD-TWO DEPEENDENT	**$3,654.00**
ADD- 3+ DEPENDENTS	**$5,481.00**

***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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