UCONN
UNIVERSITY OF CONNECTICUT

2026-2027 HEALTH INSURANCE ENROLLMENT FORM- FALL-ANNUAL

FULL POLICY YEAR
08/01– 7/31

STUDENT ONLY	**$3,763.00***
ADD-ONE DEPENDENT	**$3,723.00**
ADD-TWO DEPEENDENT	**$7,446.00**
ADD- 3+ DEPENDENTS	**$11,169.00**

***Includes $40 student admin fee**

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

DATE OF BIRTH (MM/DD/YYYY): _____ **NetID#:** _____

SEX: ☐ MALE ☐ FEMALE ☐ NON-BINARY

SOCIAL SECURITY #: _____/_____/_____ **UCONN Email:** _____

U.S. ADDRESS: _____

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

CAMPUS: ☐ STORRS ☐ REGIONAL

STUDENT LEVEL: ☐ U-GRAD ☐ GRAD ☐ MEDICAL ☐ DENTAL ☐ MED/DENT RESIDENT

FULL TIME: ☐ **YES** ☐ **NO** _____ # CREDITS CURRENT REGISTRATION (IN-PERSON ONLY)

HOME/CELL PHONE: _____

Enter Dependent Information Here:

SPOUSE/PARTNER:

LAST NAME: _____ FIRST NAME: _____ MI_____

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

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

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

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

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

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

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

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

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

Acknowledgements: Check off

By my signature here:

☐ I acknowledge that I have reviewed the coverage available under the 2026-2027 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 coverage period purchased. (Exception: Entering active military duty)

☐ 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

26 Clark Lane, Waterford CT 06385

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: Accts Rec.

PAYMENT SOURCE: _____

Notes: _____

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