

Enrollment Form for Health Service Program 2009-10

Student's Name: _____

PID/UNI: _____

School Attending: _____

Semester: _____

Number of Credits: _____

Columbia E-Mail Address: _____

Please enroll me for the Health Service fee for the following semester

<input type="checkbox"/> Fall 2009	09/01/09 - 01/18/10	\$387
<input type="checkbox"/> Spring 2010	01/19/10 - 08/31/10	\$387

By signing below, I authorize Health Services at Columbia to bill my student account at the rate(s) indicated above.

I understand that the Health Service Fee does NOT provide insurance coverage. I accept responsibility for any additional fees incurred such as prescriptions, laboratory, radiology (x-ray) testing and outside medical consultations.

I am aware that it is my responsibility to submit claims for additional charges to my Insurance carrier. I understand that the fee is **non-refundable once this form is processed.**

Signature: _____ Date _____

Received by HS Staff: _____ Date _____

Please Print Name

COMMENTS: _____

FOR OFFICE USE ONLY:

Processed by _____ Date: _____