

SHIP ENROLLMENT FOR DEPENDENT(S) 2022-2023

Please return by _____

Complete, sign, and return this form to:
FSA Services: studenthealthinsurance@stonybrook.edu
Questions? Call: 631-632-6054



Full Name _____
(Student Last Name) (Student First Name)

SBU ID # _____ Date of Birth _____ Male ____ Female ____
(Month, Day, Year)

Address _____
(Street) (Town/City) (State) (Zip)

Phone Number _____ Email _____
(Area Code)

Check boxes that apply to **STUDENT** enrollment already completed:

- | | | |
|--|---|---|
| <input type="checkbox"/> Medical student | <input type="checkbox"/> Nursing | <input type="checkbox"/> Other Graduate Program _____ |
| <input type="checkbox"/> first year | <input type="checkbox"/> Dental | <input type="checkbox"/> Undergraduate |
| <input type="checkbox"/> second year | <input type="checkbox"/> Dental Post-Graduate | <input type="checkbox"/> IEC |
| <input type="checkbox"/> third year | <input type="checkbox"/> Health Technology | <input type="checkbox"/> full time; # of semester credits _____ |
| <input type="checkbox"/> fourth year | | |
| <input type="checkbox"/> Fall 2022 | <input type="checkbox"/> Spring/Summer 2023 | |

DEPENDENT(S)

Spouse** name: last, first _____ Date of Birth _____ Male ____ Female ____

Address _____

Child's name: last, first _____ Date of Birth _____ Male ____ Female ____

Address _____

Child's name: last, first _____ Date of Birth _____ Male ____ Female ____

Address _____

Child's name: last, first _____ Date of Birth _____ Male ____ Female ____

Address _____

(for more entries, use reverse of form)

** If domestic partner, contact the Health Insurance Office for a special questionnaire that must be completed.

CHECK OFF APPLICABLE BOX(ES): DO NOT SEND IN PAYMENT AT THIS TIME

- | | | |
|---|--|---|
| <input type="checkbox"/> Spouse/Partner | <input type="checkbox"/> Fall \$1,745.25 (Eff: ____ Prorate: \$____) | <input type="checkbox"/> Spring/Summer \$2,405.25 (Eff: ____ Prorate: \$____) |
| <input type="checkbox"/> 1 Child | <input type="checkbox"/> Fall \$1,745.25 (Eff: ____ Prorate: \$____) | <input type="checkbox"/> Spring/Summer \$2,405.25 (Eff: ____ Prorate: \$____) |
| <input type="checkbox"/> 2 or more children | <input type="checkbox"/> Fall \$3,490.50 (Eff: ____ Prorate: \$____) | <input type="checkbox"/> Spring/Summer \$4,810.50 (Eff: ____ Prorate: \$____) |

Student Signature _____ Date _____

For FSA Office Use Only

Insurance Office Initials _____ Faxed to FSA _____

Initials _____ Date Entered _____