

COLUMBIA INTERNATIONAL UNIVERSITY STUDENT HEALTH PLAN ENROLLMENT**2007-2008**

Student's Name _____ Student ID# _____

Mailing Address (U.S.) _____ City _____ State _____ Zip _____

Student's Phone # _____ Student's Date of Birth _____ Social Security # _____

Enrollment Cost	Annual Premium	Fall Premium	Spring Premium
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<input type="checkbox"/> Student Only	<input type="checkbox"/> \$ 725.00	<input type="checkbox"/> \$ 302.00	<input type="checkbox"/> \$ 423.00
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<input type="checkbox"/> Spouse	<input type="checkbox"/> \$1,815.00	<input type="checkbox"/> \$ 756.00	<input type="checkbox"/> \$1,059.00
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<input type="checkbox"/> Child(ren)	<input type="checkbox"/> \$1,030.00	<input type="checkbox"/> \$ 429.00	<input type="checkbox"/> \$ 600.00
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If Spouse and/or Dependent coverage is selected, please complete the following:

Name	Age	Date of Birth	Social Security #
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Spouse _____	_____	_____	_____
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Child _____	_____	_____	_____
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Child _____	_____	_____	_____
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Child _____	_____	_____	_____
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Student Signature _____ Date _____

Please be sure to sign this form. Make checks payable to: Columbia International University and return to:
Student Health Center, P.O. Box 3122, Columbia, SC 29230