

**COLUMBIA INTERNATIONAL UNIVERSITY STUDENT HEALTH PLAN ENROLLMENT****2008-2009**

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"/> \$ 780.00	<input type="checkbox"/> \$ 325.00	<input type="checkbox"/> \$ 455.00
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<input type="checkbox"/> Spouse	<input type="checkbox"/> \$1,953.00	<input type="checkbox"/> \$ 813.00	<input type="checkbox"/> \$1,139.00
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<input type="checkbox"/> Child(ren)	<input type="checkbox"/> \$1,108.00	<input type="checkbox"/> \$ 462.00	<input type="checkbox"/> \$ 646.00
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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