

COLUMBIA INTERNATIONAL UNIVERSITY STUDENT HEALTH PLAN ENROLLMENT**2009-2010**

Student's Name _____ Student ID# _____

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

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

Enrollment Cost	Annual Premium	Fall Premium	Spring Premium
<input type="checkbox"/> Student Only	<input type="checkbox"/> \$ 780.00	<input type="checkbox"/> \$ 325.00	<input type="checkbox"/> \$ 455.00
<input type="checkbox"/> Spouse	<input type="checkbox"/> \$1,953.00	<input type="checkbox"/> \$ 813.00	<input type="checkbox"/> \$1,139.00
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> \$1,108.00	<input type="checkbox"/> \$ 462.00	<input type="checkbox"/> \$ 646.00

If Spouse and/or Dependent coverage is selected, please complete the following:

Name	Age	Date of Birth
Spouse _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____

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