# ENROLLMENT FORM
# INTERNATIONAL STUDENT AND SCHOLAR HEALTH INSURANCE

***Note: All fields must be answered in full to properly process your insurance enrollment.***

**Last Name (Family Name)** _____

**First Name (Given Name)** _____ **Middle Name** _____

**Stony Brook ID Number** _____ **Date of Birth** [Month/Day/Year] ___/___/___ **Male** ☐ **Female** ☐

**Home Country (Complete Name)** _____

**Date of Application** ___/___/___ Month/Day/Year

Academic Department: _____

Stony Brook University 11794 - _____

Mailing Address: _____

_____
City State Zip

Local Phone Number: _____

E-Mail Address: _____

**Study Abroad Location [if U.S. citizen or perm. resident]** _____

**Status:** ☐ **F Visa** ☐ **J Visa** ☐ **H Visa** ☐ **Other International Visa** ☐ **U.S. Citizen/Permanent Resident**

☐ Undergraduate Student (S887) ☐ Graduate Student (S887) ☐ Professor, Scholar, Researcher (A132)

☐ Practical Training Participant (A132) ☐ Outbound American Student (A132) ☐ Outbound American Faculty/Staff/Scholars (A132)

**1-** Full Insurance: Dates of Coverage: ___/___/___ (Month/Day/Year) to ___/___/___ (Month/Day/Year) = ____ months @ $_____/mo = $_____

**2-** Medical Evacuation and Reparation **ONLY**:

Dates of Coverage: ___/___/___ (Month/Day/Year) to ___/___/___ (Month/Day/Year) = ____ months @ $_____/mo = $_____ TOTAL AMT DUE: $_____

**NOTE: Insurance must be purchased in monthly increments (but cannot be purchased past August 15)**

_____ _____

***Signature (in ink)*** ***Date Signed***

*This form must be sent/brought with your payment to the Student Financial Services Office located in the Stony Brook Union, 2nd Floor, Suite 207.*
*The cashier will keep one copy, and return one copy to you if you pay in person. Checks should be made out to STONY BROOK UNIVERSITY, I.F.R. ACCT. #900563*
*Insurance ID Cards will be sent via email.*
*International Scholars must see a Health Insurance Advisor in International Services before enrolling.*
***Note: Dependents are enrolled by a separate process.***

***Health Insurance Advisor Approval:*** _____ ***Bursar's Receipt:*** _____

Dependent Names: _____

Must purchase insurance by ___/___/___ (Month/Day/Year) Must be renewed by ___/___/___ (Month/Day/Year)

Questions about your payment and enrollment? International Visiting Scholars: contact Visa and Immigration Services (631) 632-4685.
All Students and Stony Brook Professors/Faculty/Staff: contact Student Health Ins. Office, SBU Campus Store, Melville Library (631) 632-6054. 05/23