

SHIP ENROLLMENT FOR STUDENTS 2025-2026

Please return by _____

Complete, sign, and return this form to:

ASA Services: studenthealthinsurance@stonybrook.edu

Questions? Call (631) 632-6054



Stony Brook
University

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:

- | | | |
|--|---|---|
| <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 | | |

☐ Plan @ \$5,701.00 (billed per semester: fall \$2,389.74; spring/summer \$3,311.26)

CHOOSE ONE OR BOTH: (to be billed to Student Account)

- | | |
|--|--|
| <input type="checkbox"/> Fall 2025 | <input type="checkbox"/> Spring/Summer 2026 |
| <input type="checkbox"/> Effective _____ (prorate: \$ _____) | <input type="checkbox"/> Effective _____ (prorate: \$ _____) |

Student Signature _____ **Date** _____

For ASA Office Use Only

Prorated: Dates _____ Amounts \$ _____

Prorated: Dates _____ Amounts \$ _____

Initials _____ Date Entered _____

Instructions _____