SHIP ENROLLMENT FOR STUDENTS 2023-2024

Please return by _____

Complete, sign, and return this form to:
FSA 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:

☐ Medical student   ☐ Nursing   ☐ Other Graduate Program _____

  ☐ first year   ☐ Dental   ☐ Undergraduate

  ☐ second year   ☐ Dental Post-Graduate   ☐ IEC

  ☐ third year   ☐ Health Technology   ☐ full time; # of semester credits _____

  ☐ fourth year

☐ Plan @ $5,278.50 (billed per semester: fall $2,206.65; spring/summer $3,071.85)

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

☐ Fall 2023   ☐ Spring/Summer 2024

☐ Effective _____ (prorate: $)   ☐ Effective _____ (prorate: $)

Student Signature _____ **Date** _____

For FSA Office Use Only

Prorated: Dates _____ Amounts $ _____

Prorated: Dates _____ Amounts $ _____

Initials _____ Date Entered _____

Instructions _____