SHIP ENROLLMENT FOR DEPENDENT(S) 2024-2025

Please return by ____________

Stony Brook University

Complete, sign, and return this form to:
FSA Services: studenthealthinsurance@stonybrook.edu
Questions? Call: 631-632-6054

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 to **STUDENT** enrollment already completed:

- ☐ Medical student
  - ☐ first year
  - ☐ second year
  - ☐ third year
  - ☐ fourth year
- ☐ Nursing
- ☐ Dental
  - ☐ Dental Post-Graduate
- ☐ Health Technology
- ☐ Other Graduate Program ____________
- ☐ Undergraduate
- ☐ IEC
- ☐ full time; # of semester credits ____________

☐ Fall 2024 ☐ Spring/Summer 2025

DEPENDENT(S)

Spouse** name: last, first ____________________ Date of Birth __________ Male ____ Female ________

Address ____

Child's name: last, first ____________________ Date of Birth __________ Male ____ Female ________

Address ____

Child's name: last, first ____________________ Date of Birth __________ Male ____ Female ________

Address ____

Child's name: last, first ____________________ Date of Birth __________ Male ____ Female ________

Address ____

(for more entries, use reverse of form)

** If domestic partner, contact the Health Insurance Office for a special questionnaire that must be completed.

CHECK OFF APPLICABLE BOX(ES): DO NOT SEND IN PAYMENT AT THIS TIME

☐ Spouse/Partner	☐ Fall $2,336.29 (Eff: ____ Prorate: $____)	☐ Spring/Summer $3,237.21 (Eff: ____ Prorate: $____)
☐ 1 Child	☐ Fall $2,336.29 (Eff: ____ Prorate: $____)	☐ Spring/Summer $3,237.21 (Eff: ____ Prorate: $____)
☐ 2 or more children	☐ Fall $4,672.58 (Eff: ____ Prorate: $____)	☐ Spring/Summer $6,474.42 (Eff: ____ Prorate: $____)

Student Signature ______________________________ **Date** ____________

For FSA Office Use Only

Insurance Office Initials ____________________ Faxed to FSA ____________________

Initials ____________________ Date Entered ____________________