SHIP ENROLLMENT FOR STUDENTS 2024-2025

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
  - ☐ 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 _____

☐ Plan @ $5,573.50 (billed per semester: fall $2,336.29; spring/summer $3,237.21)

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

☐ Fall 2024
☐ Effective _____ (prorate: $)

☐ Spring/Summer 2025
☐ Effective _____ (prorate: $)

Student Signature _____ **Date** _____

For FSA Office Use Only

Prorated: Dates _____ Amounts $ _____

Prorated: Dates _____ Amounts $ _____

Initials _____ Date Entered _____

Instructions _____