SHIP ENROLLMENT FOR DEPENDENT(S) 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 _____ Gender ◯ 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 2025
☐ Spring/Summer 2026

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
☐ 1 Child
☐ 2 or more children

☐ Fall $2,389.74 (Eff: ____ Prorate: $ ____)
☐ Fall $2,389.74 (Eff: ____ Prorate: $ ____)
☐ Fall $4,779.48 (Eff: ____ Prorate: $ ____)

☐ Spring/Summer $3,311.26 (Eff: ____ Prorate: $ ____)
☐ Spring/Summer $3,311.26 (Eff: ____ Prorate: $ ____)
☐ Spring/Summer $6,622.52 (Eff: ____ Prorate: $ ____)

Student Signature _____ **Date** _____

For ASA Office Use Only

Insurance Office Initials _____ Faxed to ASA _____

Initials _____ Date Entered _____