ANNUAL MANDATORY INSURANCE ENROLLMENT FORM 2016-2017

You may email this completed form to health@swarthmore.edu
or mail to: Swarthmore College, Attn: Student Health and Wellness Center, 500 College Avenue, Swarthmore, PA 19081

Students (in lieu of completing this form) may opt to update this insurance information on-line through mySwarthmore
or Parents can update this insurance information on-line by logging into their E-Bill account (and selecting the “Student
Health Insurance” tab). If a parent is not currently enrolled in E-Bill, they may find out how to enroll by visiting the
following link www.swarthmore.edu/e-bill (and selecting Parent/Authorized User Set Up).

Print Student Name: ___________________________ Class Year ___________________________

Date of Birth ___________________________ Student id# ___________________________

____ OPTION (1): My insurance listed below meets the College requirements listed on the back of this form and I wish to
WAIVE the Swarthmore College Health Plan.

Signature (Student or Parent): _______________________________________________________

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (front and back) TO THIS FORM

**Also include a copy of any separate prescription card**

Insurance Company Name: __________________________________________________________

Insurance Company Address: _______________________________________________________

_________________________________________ GROUP# ___________________________

ID# ______________________________________

Insurance Company Phone Number: _________________________________________________

Name of policy holder: ___________________________________________________________

Address of policy holder: ________________________________________________________

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Phone number of policy holder: ___________________________________________________

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PLEASE COMPLETE THIS SECTION TO ENROLL IN THE COLLEGE HEALTH INSURANCE PLAN

____ OPTION (2): I would like to enroll in the College Health Insurance Plan at the rate of $1,387 for the year beginning
August 17, 2016 and ending August 16, 2017.

____ Due to economic hardship, I would like to be considered for a discounted rate. I do not have other health insurance
that meets the college minimum requirements.

Signature: ________________________________________________________________