



RUTGERS
UNIVERSITY

Office of Student Insurance
Hurtado Health Center
11 Bishop Place, Room 228
New Brunswick, NJ 08901

Main: (848) 932-8285
Fax: (732) 932-3331
Email: insure@rci.rutgers.edu
http://riskmanagement.rutgers.edu

Request for Health Insurance for Graduate Students

Registered as Part-Time and Treated as Full-Time

This form is required for Graduate Students registered for fewer than 9 credits and considered full time by their graduate program and who want to enroll in the student insurance plan at the full time rate. This form must be submitted along with payment each semester.

Note: This form is not to be used by students on University F-1, F-2, J-1 or J-2 Visa sponsorship.

SELECT ONE SEMESTER ONLY

The rate for the FALL 2014 is \$711.00. Effective date 08/15/14 - 1/14/15 Deadline to enroll: October 10, 2014
Student Health Insurance Premium of \$711 to be paid by Graduate School Department Student Other

The rate for the SPG/SMR 2014 is \$985.00. Effective date 1/15/15– 8/14/15 Deadline to enroll: March 15, 2014
Student Health Insurance Premium of \$985 to be paid by Graduate School Department Student Other

Please complete this form each semester and bring or mail it with a check payable to: Rutgers University.

Office of Student Insurance, Hurtado Health Center, 11 Bishop Place, Room 228, New Brunswick NJ 08901.

After submission, you will receive an email in 7-10 business days to your Rutgers email address from United Healthcare advising you to print your card. For benefit details call 800-505-4160 or visit www.uhcsr.com.

Please print legibly.

Student Name: Last: _____ First: _____

RU ID Number: _____ Phone: _____

Street Address: _____ APT #: _____

City: _____ State: _____ Zip code: _____

Rutgers email _____

I certify that I am completing/have completed my course work but, considered full time by my department.

Student Signature _____ **Date:** _____

For Completion by Rutgers Graduate Program Director/Dean/Authorized Personnel: I certify that the above statement is accurate.

Name of Graduate Program _____ Phone: _____

(PRINT) Name of Graduate Program Director/ Dean/Authorized Personnel _____

Signature of Program Director/Dean/Authorized Personnel _____ Date _____

OFFICE USE ONLY	Received form: mail <input type="checkbox"/> in person <input type="checkbox"/>	Amount received _____	Date Received _____
Check # _____	Date Deposited _____	School/Credits _____	Processed Date _____ Initials _____