CAMPUS HEALTH

UA STUDENT HEALTH INSURANCE underwritten by United Healthcare

VISITOR ENROLLMENT APPLICATION

Last Name_____ First Name_____MI_____

EMPLID_____ Date of Birth _____Gender_____

Phone Number _____ Email Address_____

Address _____City _____State _____ Zip Code _____

Department_____ UA Department Contact Name & Phone #_____

Anticipated date of arrival_____

Please circle one that applies to you:

Post-Doctoral Fellow J1 Visiting Scholar J1 Student Intern J1 Visiting Student

Renewal Notifications

Post-Doctoral Fellows: Sent to mailing address on application, if enrolled to the end of a coverage period.

J1 Visiting Scholars: Sent to email address on application.

Until final coverage period and premium amount is determined, please leave blank

Coverage Period: _____**through**_____ Premium Amount: _____ Reason: _____

Signature _____ Date _____

By my signature, I understand that no premium will be refunded for the time period purchased.

Return this form to:

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH SERVICE INSURANCE OFFICE
1224 E. LOWELL STREET, TUCSON, ARIZONA 85721-0095
Submit documentation securely to: https://web.health.arizona.edu/cgi-bin/secure/insform.php/
FAX: 520-626-8616