



**CAMPUS
HEALTH**

Arizona Board of Regents
STUDENT HEALTH INSURANCE
underwritten by **aetna**

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 # _____

Office Use Only: Plan Code 102 Location Code 1100007

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