



**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 10 \_\_\_\_\_ Location Code 110000 \_\_\_\_\_

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>

**FAX: 520-626-8616**