

Student Health Insurance Dependent Enrollment Form

PLEASE PRINT:

STUDENT LAST NAME	FIRST	MIDDLE	Z-ID #
LOCAL ADDRESS		APT #	
CITY	STATE	ZIP	DATE OF BIRTH
SEX <input type="checkbox"/> MALE	APPLICATION FOR	<input type="checkbox"/> FALL	
<input type="checkbox"/> Female		<input type="checkbox"/> SPRING/SUMMER	
		<input type="checkbox"/> SUMMER ONLY	

DEPENDENT NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH	SEX	RELATIONSHIP TO STUDENT

ARE THE DEPENDENTS LISTED ABOVE COVERED BY OTHER HEALTH INSURANCE? _____

ACCEPTANCE OF THIS APPLICATION IS NOT A GUARANTEE OF COVERAGE. STUDENTS MUST BE ENROLLED IN THE PLAN AND ACTIVELY ATTENDING CLASSES FOR 6 OR MORE SEMESTER HOURS TO BE ELIGIBLE FOR BENEFITS FOR THEMSELVES AND THEIR DEPENDENTS. ELIGIBLE DEPENDENT CHILDREN MUST BE UNDER AGE 26. REFER TO THE "STUDENT HEALTH INSURANCE PLAN BROCHURE" FOR SPECIFIC ENROLLMENT DEADLINES, ELIGIBILITY INFORMATION, AND POLICY TERM EXPIRATION DATES.

I UNDERSTAND THE ABOVE TERMS OF APPLICATION AND I AGREE THE "TOTAL FEE" SHOWN BELOW WILL BE CHARGED TO MY NIU REVOLVING CREDIT PLAN ACCOUNT. SUCH AMOUNT IS SUBJECT TO SETTLEMENT ACCORDING TO THE TERMS OF THAT PLAN AND WILL APPEAR ON THE NEXT STATEMENT OF ACCOUNT. (DO NOT SEND MONEY WITH THIS APPLICATION).

I UNDERSTAND THAT THIS APPLICATION IS FOR ONE SEMESTER ONLY AND THAT I MUST REAPPLY FOR DEPENDENT COVERAGE BY THE PUBLISHED DEADLINE EACH FALL AND SPRING SEMESTER IF CONTINUOUS COVERAGE IS DESIRED.

⇒ _____
 Signature _____
 Date

Coverage	Fee
Spouse	_____
Child (x _____)	_____
Total Fee \$	

Enrollment Type	Check one
Standard Enrollment	_____
Mid-Term Enrollment	_____
Reinstatement	

Effective Date: _____
<input type="checkbox"/> Fall
<input type="checkbox"/> Spring
<input type="checkbox"/> Summer

Approval: _____ Invoice Date: _____ Enroll Form: _____