Dependent Enrollment Form for Students
With the Student Accident and Sickness Health Insurance Plan

A. Student Information

Student Name: _____ **SS #:** _____

Mailing Address: _____

B. Premium Per Semester (Check Plan Applied For)

	Term of Insurance	
Type of Plan	**8/15/2008 to 1/21/2009**	**1/22/2009 to 8/15/2009**
Student and Spouse Only	[ ] $541.50	[ ] $541.50
Student & Spouse & Child(ren)	[ ] $794.50	[ ] $794.50
Student & Child(ren) only	[ ] $436.00	[ ] $436.00

C. Dependents

I wish to extend my own coverage to include my dependents listed below. I fully understand that eligible dependents only include 1) my spouse and 2) my unmarried child or children (including stepchildren and adopted children) under the age of 19 who are not self supporting. I understand that the dependents listed below must reside with me and that they will not have use of the Student Health Center.

Dependent's Name	Age	Date of Birth	Relationship to Student

D. Student Signature

I understand and agree that this insurance will not be effective until a) the first day of the insurance term as selected above under "B. Premium Per Semester" or 2) the date this enrollment form and valid payment of the full premium are received by the Company or its authorized agent, whichever date is later.

_____

Student Signature Date

E. Payment

Make check or money order payable to: SUNY Plattsburgh

Forward check or money order to: SUNY Plattsburgh, Student Accounts, 101 Broad Street, Plattsburgh NY 12901-2681