

COLLEGE OF THE ATLANTIC
Application for Dependent Insurance

2007-2008

Please enroll the person(s) named below in the Student Accident and Sickness Insurance Program as dependent(s) of:

NAME OF STUDENT - PLEASE PRINT

Spouse/Domestic Partner Only: \$1,200 Annual \$800 Second Semester

Child/Children: \$ 765 Annual \$510 Second Semester

List Dependents to be insured below. Dependent coverage is available only if the student is also insured under this plan.

Spouse: _____
LAST NAME FIRST NAME MI DATE OF BIRTH

Domestic Partner (Please complete affidavit): _____

Child: _____

Child: _____

Student Signature _____ **Date** _____

Note: The full premium must accompany this form. Please make check or money order payable and mail to:
Cross Insurance, PO Box 3028, Lewiston, ME 04243-3028

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