

**University of Southern Maine
Dependent Health Insurance Enrollment Form
Policy Period 2007-2008**

Application for Dependent Insurance Coverage

I wish to enroll my dependents in the USM Student Health Insurance Plan offered by Cross Insurance and The Chickering Group, an Aetna Company. (Note: **The student must be covered by the Student Health Plan to enroll dependents**). My spouse/domestic partner and/or dependent children under age 19 residing in my household to be covered as follows:

NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	GENDER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that coverage is not effective until the effective date the policy, September 1, 2007 for the annual term or January 14, 2008 for the spring term, or subsequently on the date my application and premium are received by the company or its agent. **The open enrollment period ends on October 5, 2007 for the annual term and February 15, 2008 for the spring term.** I also understand that this insurance does not cover injury sustained or sickness, which manifests itself prior to the effective date of my insurance.

Premium Rates

Important Note: Dependent premiums are in addition to the student premium, the premiums below do not include the amount for the student.

	<u>Annual Rate*</u>	<u>Spring Term</u>
One Dependent	\$3,484	\$2,179
Two or More Dependents	\$6,944	\$4,338

* Annual coverage for dependents is payable on a Two Installment Basis (Fall \$1,742 and Spring \$1,742 for one dependent/Fall \$3,472 and Spring \$3,472 for two or more dependents). Coverage for all insured dependents will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the initial Enrollment Form and premium is received. **For dependents with the two installment option, a bill will be issued by Cross Insurance in December 2007. The second installment payment must be received by Cross Insurance no later than January 31, 2008, or dependent coverage will terminate at 12:01 a.m. on March 1, 2008.**

Please complete the information below.

Student Name: _____ Student Social Security Number: _____
 Address _____ City _____ State _____ Zip _____
 Phone Number: (____) _____ E-Mail Address: _____

I understand that if my premiums are not received by the company by the date listed above, that I will be in default and my dependent coverage will be canceled. This plan will not be reinstated if premiums are defaulted. Please note that incomplete applications will cause delay in your insurance coverage. Complete information and premium must be received to begin insurance coverage. Coverage for insured dependents terminates in accordance with the termination provisions described in the Master Policy.

**Please mail this form and payment to:
 Cross Insurance
 P.O. Box 3028
 Lewiston, ME 04243-3028
 Make checks payable to Cross Insurance**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

