

2008–2009 UNIVERSITY OF MAINE AT MACHIAS APPLICATION FOR DEPENDENT INSURANCE

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

NAME OF STUDENT - PLEASE PRINT				STUDENT ID #	
Spouse/Domestic Partner Only:	<input type="checkbox"/> \$1,375 Annual—9/1/08–9/1/09	<input type="checkbox"/> \$922 Second Semester—1/1/09–9/1/09			
Child/Children:	<input type="checkbox"/> \$ 832 Annual—9/1/08–9/1/09	<input type="checkbox"/> \$558 Second Semester—1/1/09–9/1/09			
List Dependents to be insured below. Dependent coverage is available only if the student is also insured under this plan.					
<input type="checkbox"/> Spouse:	_____	_____	_____	_____	_____
	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER
<input type="checkbox"/> Domestic Partner (Please complete affidavit):	_____	_____	_____	_____	_____
	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER
Child:	_____	_____	_____	_____	_____
	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER
Child:	_____	_____	_____	_____	_____
	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER
Address:	_____	_____	_____	_____	_____
	STREET / P.O. BOX		CITY	STATE	ZIP
Student Signature	_____		Date	_____	

DEF-J3A13

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