University of Southern Maine
International Students and Scholars Health Insurance Plan
Dependent Health Insurance Enrollment Form
Policy Period 2008-2009

Application for Dependent Insurance Coverage

I wish to enroll my dependents in the USM International Students and Scholars Health Insurance Plan offered by Cross Insurance and Aetna Student Health. (**Note: The student must be covered by the International Students and Scholars 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, August 15, 2008 for the annual term or January 1, 2009 for the spring term, or subsequently on the date my application and premium are received by the company or its agent. I also understand that this insurance does not cover injury sustained or sickness, which manifests itself prior to the effective date of my insurance.

Once enrolled, a dependent may not be disenrolled and dependent health insurance coverage cannot be cancelled. Premium paid for dependent health insurance coverage is fully earned and non-refundable.

Premium Rates

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

	Annual Rate	Spring Term
Spouse	$4,871	$3,016
Child(ren)	$2,661	$1,647

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.

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.