

COLLEGE OF THE ATLANTIC
Application for Dependent Insurance

2009–2010

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: \$1,425 Annual \$950 Second Semester

Child/Children: \$ 910 Annual \$607 Second Semester

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

LAST NAME

FIRST NAME

MI

DATE OF BIRTH

Spouse: _____

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

DEF-J3A44