

2009–2010 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"/> \$1,562 Annual—9/1/09–9/1/10	<input type="checkbox"/> \$1,048 Second Semester—1/1/10–9/1/10			
Child/Children:	<input type="checkbox"/> \$ 945 Annual—9/1/09–9/1/10	<input type="checkbox"/> \$ 633 Second Semester—1/1/10–9/1/10			
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