2014-15

MCPHS UNIVERSITY
HEALTH INSURANCE PLAN DEPENDENT ENROLLMENT FORM

STUDENT'S NAME _____________________________________ Student ID #____________________________Date of Birth: _______ M / F

ADDRESS____City:______________________________State:__________________Zip:

Make check payable to: University Health Plans
Mail to: One Batterymarch Park, Quincy, MA 02169

Coverage Costs

(Check appropriate boxes):	9/1/14 - 8/31/15	9/1/14-12/31/14	1/1/15 – 8/31/15	5/1/15 - 8/31/15
BASIC COVERAGE	Full Year	Fall	Spring	Summer
Family	☐$ 10,228	☐ $ 3,413	☐$ 6,821	☐$ 3,413

(Family Premium additional to Student Premium)

NOTE: Dependent enrollment period starts and ends concurrently with that of the Student, unless the student is enrolling a newborn baby

NAME OF SPOUSE:____Date of Birth: ________________ M / F

NAME(S)OF DEPENDENT CHILDREN:____Date of Birth:_________________M / F

NAME(S)OF DEPENDENT CHILDREN:____Date of Birth:_________________M / F

NAME(S)OF DEPENDENT CHILDREN:____Date of Birth:_________________M / F