MASSACHUSETTS COLLEGE OF PHARMACY AND HEALTH SCIENCES **2012-13**
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):	9/1/12 - 9/1/13	9/1/12-1/1/13	1/1/13 – 9/1/13	5/1/13 - 9/1/13
BASIC COVERAGE	Full Year	Fall	Spring	Summer
Family (Additional	☐$ 9,065	☐ $ 3,025	☐$ 6,045	☐$ 3,025

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