MCPHS UNIVERSITY **2016-17**
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):	9/1/16 - 8/31/17	9/1/16-12/31/17	1/1/17 – 8/31/17	5/1/17 - 8/31/17
BASIC COVERAGE	Full Year	Fall	Spring	Summer
Family	☐$ 8,120	☐ $ 2,710	☐$ 5,415	☐$ 2,710

(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