THE NEW SCHOOL
2016-2017 STUDENT HEALTH INSURANCE PLAN
DEPENDENT ENROLLMENT FORM

PART A: Student Information – All fields are required.

First Name _____ Last Name _____ DOB ____/____/_____ Gender: _____

Address _____ City_____ State_____ Zip_____

Email Address _____ TNS ID# _____

PART B: Premium – Check the premium that applies to your enrollment request.

Annual Coverage 8/20/16 – 8/19/17

(Due at time of enrollment - deadline is 9/20/16)

Spouse	☐	$2,999
Child	☐	$2,999
2+ Children	☐	$5,998

PREMIUM TOTAL: _____

Spring Semester Coverage 1/15/17 – 8/19/17

(Due at time of enrollment - deadline is 2/14/17)

PREMIUM

Spouse	☐	$1,786
Child	☐	$1,786
2+ Children	☐	$3,572

PREMIUM TOTAL: _____

PART C: Dependent(s) Information – List dependent(s) for whom you are requesting enrollment.

	First Name	Last Name	DOB	Gender *(Circle one)*
Spouse:	_____	_____	____/____/_____	M F
Child:	_____	_____	____/____/_____	M F
Child:	_____	_____	____/____/_____	M F
Child:	_____	_____	____/____/_____	M F

PART D: Signature – By signing below, I am confirming my request to enroll the dependent(s) indicated above.

Student's Signature _____ Date _____

PART E: Submission Instructions

Your check or money order should be made payable to: University Health Plans

Your payment and enrollment form should be mailed to: University Health Plans
One Batterymarch Park
Quincy, MA 02169