2019-2020

Dartmouth Student Group Health Plan (DSGHP) Dependent Application

Dartmouth Student Group Health Plan

Mailing Address:
7 Rope Ferry Rd, HB# 6143
Hanover, NH 03755

Physical Address:
37 Dewey Field Rd, Rms 403 & 408
Hanover, NH 03755

E-mail: dartmouth.student.health.plan@dartmouth.edu
Website: http://www.dartgo.org/studentinsurance
Telephone: (603) 646-9438 & (603) 646-9449 Fax: (603) 646-8893

Student Name: ____ Class: ___________ Gender: ( ) F ( ) M
Last First Middle

Dartmouth ID#:____________________ Social Security #: ______________________________ Hinman Box #: _____________

I wish to enroll my spouse or domestic partner in the DSGHP Dependent Plan.

Relation to Student: ( ) Spouse ( ) Domestic Partner (DP)

Name: ____ Gender: ( )F ( )M
Last First Middle

Date of Birth: ___________ Social Security #:__________________________ (If applicable. Needed for tax form preparation)

Has Spouse/DP ever been a Dartmouth student? Yes ( ) No ( ) If yes, Dartmouth Identification Number: _______________________

Does Spouse/DP have other insurance coverage? Yes ( ) No ( )

Spouse/Domestic Partner E-mail: ______________________________________ Phone: ____________________

I wish to enroll my children.

Do your children have other insurance coverage? Yes ( ) No ( )

Name: ____ Gender ( )F ( )M Date of Birth:______________
Last First Middle

Relation to Student: ( ) Biological Child ( ) Step Child ( ) Adopted Child Social Security #:_________________________

Name: ____ Gender ( )F ( )M Date of Birth:______________
Last First Middle

Relation to Student: ( ) Biological Child ( ) Step Child ( ) Adopted Child Social Security #:_________________________

Name: ____ Gender ( )F ( )M Date of Birth:______________
Last First Middle

Relation to Student: ( ) Biological Child ( ) Step Child ( ) Adopted Child Social Security #:_________________________

Name: ____ Gender ( )F ( )M Date of Birth:______________
Last First Middle

Relation to Student: ( ) Biological Child ( ) Step Child ( ) Adopted Child Social Security #:_________________________

NOTE: The dependent DSGHP premium and spouse Health Access Fee are in addition to the student DSGHP premium and Health Access Fee. Dependent Applications are valid for one plan year, and must be resubmitted annually.

If enrolling dependents from the beginning of the plan year, **dependent coverage begins on September 1st. If you believe coverage should begin on a different date, please contact the DSGHP Office for information on how to do this. New students may enroll dependents when their plan begins, on August 1st, for an additional fee. Please contact the DSGHP office for this fee.

My signature below authorizes my spouse, dependent children, and/or domestic partner be enrolled into the DSGHP. I wish for their coverage to become effective: ____________________ and continue until the end of the plan year, August 31. I also authorize the DSGHP premium of $_____________ and the $420.00 annual spouse health access fee to be charged to my student account.

I understand that I must file a written notice to terminate DSGHP coverage prior to August 31. Please refer to the DSGHP plan document or website for termination dates and requirements.

I declare the above information to be true and valid. I understand that my Dependent plan coverage is considered to be secondary to other insurance (if applicable) and is subject to all plan eligibility requirements, limitations, and provisions.

Student Signature:____ Date:_________________
Must be signed by student to be valid.

Office Use Only:

Received: ____________________ Entered: ______________________ Ack'd: ____________________ TPA: ____________________________