

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 \$450.00 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: _____