ENROLLMENT: I am requesting to be enrolled into the Dartmouth Student Group Health Plan (DSGHP) during the following timeframe:

__________________ to __________________

The DSGHP premium that will be charged to my tuition account is $_______________.
(Please contact the DSGHP office for this prorated amount.)

I am requesting enrollment later than September 1, 2020 because:

_______ Dartmouth sponsored study abroad program, term(s):_______________

_______ Mid-year start date, term: _______________

_______ My coverage with another health plan was terminated involuntarily.
(You must provide a copy of the termination letter sent to you from this health plan. This application must be submitted within 31 days of termination with the other health plan.)

_______ Other (please explain)________________________________________________________________________
________________________________________________________________________

• I understand that I will automatically be re-enrolled into the plan and the fee charged to my student account each year I am eligible. If I wish to waive enrollment I need to submit a completed waiver by the deadline. I also understand that my enrollment can not be cancelled except with an advanced written application to terminate December 31st or March 31st, as described in the DSGHP Plan Document found at the website below.

• If you have dependents you would like to enroll into the plan for an additional fee:
Download, print, complete, and submit the dependent application to the DSGHP Office with this enrollment form. Dependent Applications are available at:

http://www.dartgo.org/studentinsurance

Signature of Student or Parent/Guardian __________________________ Date __________________________

Office Use Only:
Audit verification:__________________________________________________________________________________________________________