2024-2025

Dartmouth Student Group Health Plan (DSGHP) Dependent Application

Dartmouth Student Group Health Plan
Mailing Address:
7 Rope Ferry Rd, HB# 6143
Hanover, NH 03755

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

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

Dartmouth ID#:____________________ Social Security #: ________________________ Hinman Box #: __________

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

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

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

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

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

Spouse E-mail: ____________________________________ Phone: __________________

I wish to enroll my children in the DSGHP Dependent Plan.

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 #:____________________

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.**

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

My signature below authorizes my spouse and/or dependent child/children to 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 **$495.00** 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.