Dartmouth Student Group Health Plan (DSGHP)
Extension of Eligibility (EOE) Program
2025-2026 Enrollment Form

Student Name/ID: _____ /_____

Social Security No.: _____

Mailing Address: _____

_____

Daytime Telephone: _____

I wish to enroll the following person(s) in health coverage under the EOE for the month(s) of _____ to _____:

( ) Myself ( ) My Dependents

Name:_____ Relation:_____ SS#:_____

Name:_____ Relation:_____ SS#:_____

Name:_____ Relation:_____ SS#:_____

The cost for of the EOE is **$1,415** per person, per month. This can be done for the months of September through February only, and must start in September. Additional months must be consecutive.

Number of persons to be covered: _____

Total cost of coverage requested: _____

Please choose how you wish to be billed:

____ I authorize the DSGHP office to bill my tuition account the above amount.

(Mailing address must be provided above for the Campus Billing Office to send the bill to.)

Signature _____ Date