

Michigan State University

2016–2017 Health Insurance Enrollment Form

Visiting Scholars

In order to enroll, steps 1 through 4 must be completed. Please print clearly.

1. COMPLETE ALL STUDENT INFORMATION. INCOMPLETE INFORMATION WILL DELAY PROCESSING!			
STUDENT'S LAST NAME	FIRST NAME	MI	
MSU STUDENT'S APID/ZPID NUMBER	EMAIL ADDRESS		
MAILING ADDRESS			APT #
CITY	STATE	ZIP	
STUDENT'S PHONE NUMBER	STUDENT'S DATE OF BIRTH (MM/DD/YYYY)		<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE

2. LIST DEPENDENTS TO BE INSURED. DEPENDENT COVERAGE IS ONLY AVAILABLE IF THE STUDENT IS COVERED.			
LAST NAME	FIRST NAME	DATE OF BIRTH (MM/DD/YY)	GENDER
SPOUSE/DOMESTIC PARTNER			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CHILD			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CHILD			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CHILD			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE

DAILY**
Please multiply the rate and number of days to get your total premium.

SCHOLAR	<input type="checkbox"/> \$ 6.00 x _____ (# of days) = \$ _____
SPOUSE/DOMESTIC PARTNER	<input type="checkbox"/> \$ 6.00 x _____ (# of days) = \$ _____
ONE CHILD	<input type="checkbox"/> \$ 6.00 x _____ (# of days) = \$ _____
TWO OR MORE CHILDREN	<input type="checkbox"/> \$ 12.00 x _____ (# of days) = \$ _____
TOTAL	\$ _____

**** Please fill in the dates for which you are requesting coverage.**

Dependents cannot be enrolled beyond the primary insured coverage dates.

Effective Date _____ Termination Date _____

Coverage dates may not extend beyond August 14, 2017. New rates will apply after this date.

