

*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

**Must purchase a minimum of 30 days of coverage unless the period of time in the United States is less. If purchasing less than 30 days of coverage, scholar will need to provide proof for the full period of time in the United States.**  
**Please multiply the rate and number of days to get your total premium.**

STUDENT	<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) = \$ _____
<b>TOTAL</b>	<b>\$ _____</b>

**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 15, 2021. New rates will apply after this date.**

