



Dependant Health Insurance Form

Family Name	First Name	Student ID Number
E- Mail Address		Date of Birth

I want to add a spouse and/or child to my CSU Health Insurance Plan

Spouse's Name _____
Date of Birth _____

Child's Name _____
Date of Birth _____

Child's Name _____
Date of Birth _____

Child's Name _____
Date of Birth _____

YOU MUST READ AND SIGN THIS STATEMENT

I certify that the above information is accurate and complete. I request the dependant insurance fee be added to my bursar bill. I understand that I will have to notify CISP EACH SEMESTER I WISH TO ADD A DEPENDANT.

Signature _____ Date _____

FOR MORE INFORMATION CALL 216-687-3910

Cleveland State University USE ONLY	
<input type="checkbox"/> Dependant added	_____