



# 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 \_\_\_\_\_

Sex (Circle one): Male or Female

I want to enroll my spouse in:    \_\_\_ Fall Semester Only  
   \_\_\_ Spring/Summer Semester Only  
   \_\_\_ Annual Plan

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Sex (Circle one): Male or Female

I want to enroll my child in:    \_\_\_ Fall Semester Only  
   \_\_\_ Spring/Summer Semester Only  
   \_\_\_ Annual Plan

**\*\* Add additional children on back of form**

### ***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 \_\_\_\_\_ Semester \_\_\_\_\_ Date \_\_\_\_\_

FOR MORE INFORMATION CALL 216-687-3910

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