Mail application to:
Student Insurance Office
Health Services, #201
Northern Illinois University
DeKalb, Illinois 60115

Dependent Enrollment Form
NIU Student Health Insurance
For One Term Only

Student Last Name                                      First                             Middle
Street Address                                                                                      Apt. #
City                                                            State                                           Zip

Check one:     ____ U.S. Citizen
                ____ Non-Immigration Visa
                ____ Permanent Resident (with Alien #)

Date of Birth ____________
Phone Number __________________________

Application is for:  □ Fall  □ Spring/Summer  □ Summer Only  Deadline: 15th calendar day of Fall/Spring semester (5th calendar day of summer session)

Dependent Name (First, Middle, Last)  Date of Birth  Sex (M/F)  Relationship to Student (Spouse/Child)

Are the dependents listed above covered by other health insurance?  ____ Yes  ____ No

Acceptance of this application is not a guarantee of coverage. Students must be enrolled in the plan and actively attending classes for 6 or more semester hours of instruction to be eligible for benefits for themselves and their dependents. Eligible dependent children must be under age 19. Refer to the “Student Health Insurance Plan Brochure” for specific enrollment deadlines, eligibility information, and policy term expiration dates.

I understand the above terms of application and I agree the “Total Fee” shown below will be charged to my NIU Revolving Credit Plan account. Such amount is subject to settlement according to the terms of that plan and will appear on the next Statement of Account. (Do not send money with this application.)

I understand that this application is for one semester/session only and that I must reapply for dependent coverage by the published deadline each fall and spring semester if continuous coverage is desired.

Date ____________  Student Signature ____________

FOR OFFICE USE ONLY

Coverage/Enrollment Fee  Enrollment Type:  Effective Date: (ONE TERM ONLY)
Spouse _____  □ Standard Enrollment  □ Fall, 200 ___ / / /
Child (X ________ ) _____  □ Mid-Term Enrollment  □ Spring, 200 ___ / / /
□ Reinstatement  □ Summer, 200 ___ / / /
Total Fee $ ________  Approval: ________
(ONE TERM ONLY)  Initial