EASTERN VIRGINIA MEDICAL SCHOOL

Health Insurance Enrollment Form
(Life-Change/Dependent Additions)

NAME (please print)_____ MALE ☐ / FEMALE ☐

PROGRAM _____ GRADUATION YEAR _____ PHONE _____

ADDRESS_____
Street Address **City, State, Zip Code**

SS#_____ DATE OF BIRTH _____

Premiums for enrollment due to life change status or adding dependents MUST be paid to the Department of Financial Services BEFORE the enrollment becomes effective.

_____ I request enrollment in The Chickering/Aetna Health Insurance student only coverage.

Explanation of life-change and date of occurrence: _____

_____

Cost: **$** _____ of policy period from _____ to _____.

_____ I would like to add my spouse to the Chickering/Aetna Health Insurance policy.

Spouse's Name_____Date of Birth_____SS#_____

Date of marriage or explanation of status-change and date of occurrence: _____

_____

Cost: **$** _____ of policy period from _____ to _____.

_____ I would like to add my child(ren) to the Chickering/Aetna Health Insurance policy.

Child's Name_____Date of Birth_____SS#_____

Child's Name_____Date of Birth_____SS#_____

Child's Name_____Date of Birth_____SS#_____

Cost: **$** _____ of policy period from _____ to _____.

STUDENT SIGNATURE_____DATE_____

PLEASE RETURN THIS FORM TO:

THE DEPARTMENT OF STUDENT AFFAIRS

LEWIS HALL