



ACE American Insurance Company
Philadelphia, PA 19103
DEPENDENT
HEALTH INSURANCE ENROLLMENT

STUDENT HEALTH INSURANCE OFFICE
CASSIDY HALL - CAMPUS BOX 46
GREELEY, COLORADO 80639
(970) 351-1915 FAX: (970) 351-3234

ENROLLMENT PERIOD: Fall Semester Type of Coverage: Spouse Children Spouse & Children
Spring Semester Premium Amount: /Semester
Summer Session Year: _____

STUDENT NAME: (Last) (First) SSN:
Bear #: _____

DATE OF BIRTH: TELEPHONE NUMBER: _____

E-MAIL ADDRESS: _____

ADDRESS: City State Zip Code

SPOUSE'S NAME / Date of Birth / Social Security

1) Child's Name / Date of Birth / Social Security # / Gender M F

2) Child's Name / Date of Birth / Social Security # / Gender M F

3) Child's Name / Date of Birth / Social Security # / Gender M F

CONDITIONS OF THIS ENROLLMENT:

I hereby request the Student Health Dependent Insurance Coverage. I understand that:

- 1) If I wish to cancel this coverage, I must submit a written request to the Student Health Insurance office on or before the last day to enroll for coverage (10th Class Day of the Semester), after which the premium is non-refundable.
2) That this coverage will be in effect beginning and ending
3) To be eligible to purchase dependent coverage, I understand that I must be enrolled in the Student Health Insurance Plan and cannot waive the insurance for the term that my dependents are insured.

I have read the above conditions and agree to them as signed below.

Signature of Student Date: _____

For Office Use Only: Comments: _____

Date Entered: Flag Changed: _____

E-Mail Sent: _____

Entered by: Eligibility: Update: _____

Benefits Book: Medicat: RxWest: # of Hours: _____

