

ASH GA ENROLLMENT FORM FY 17/18

All Graduate Assistants (GAs) employed by UMBC are eligible for participation in the policy. Enrolled GA's may also enroll their eligible spouse and/or children subject to payment of required premium. To be eligible, spouse and child must reside with the GA and the child must be under 19 years of age.

Name: _____
Last First MI

Local US Address: _____
Street City State Zip
 (Not campus address)

Campus ID Number: _____ Date of Birth: _____ Phone #: _____
Month/Day/Year

Gender: M F (Circle One) Visa Status: F1 or J1 (Circle One) Email Address: _____

I hereby acknowledge that, if for any reason I am no longer employed as a UMBC Graduate Assistant, I will be disenrolled from the insurance.

Student's Signature: _____

List Dependents to be insured

	Last Name	First Name	MI	Gender	Date of Birth
Spouse:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____

FOR DEPARTMENT USE ONLY

Please Choose Coverage:

Semester	Fall 2017	Spring/Summer 2018	Summer 2018 Only
Enrollment Dates	August 15, 2017-January 24, 2018	January 25 - August 14, 2018	May 15-Aug 14, 2018
<u>Enrollment Deadlines*</u>	<u>9/15/2017</u>	<u>2/1/2018</u>	<u>5/15/2018</u>
Student Only	\$1,997.00	\$2,475.00	\$1,128.00
Spouse Only	\$1,969.00	\$2,440.00	\$1,111.00
Each Child	\$2,020.00	\$2,504.00	\$1,140.00

Student EMPLID# _____

Employing Department _____

Chart string _____
FUND(4) PROFIN(3) DEPT(5) ACCOUNT(7) PROJECT(8) ACTIVITY(6) RESOURCE TYPE(5)

Chart string _____
FUND(4) PROFIN(3) DEPT(5) ACCOUNT(7) PROJECT(8) ACTIVITY(6) RESOURCE TYPE(5)

Authorized Department Signature _____

Department Contact / Phone Ext (Please Print) _____

For Spouse/dependent coverage ONLY

Complete only ONE of the following sections. Completion of BOTH sections will delay processing.

The department agrees to pay for additional coverage for spouse and/or children.

Chart string _____
FUND(4) PROFIN(3) DEPT(5) ACCOUNT(7) PROJECT(8) ACTIVITY(6) RESOURCE TYPE(5)

Authorized Department Signature _____

OR

I (the student) agree to pay for and hereby give the UMBC Health Services department permission to charge my account in the bursar's office for the cost of insurance for my dependents.

Student Signature _____ DATE _____

***ANY FORM RECEIVED AFTER ENROLLMENT DEADLINE WILL NOT BE PREPROCESSED**