

**ITHACA COLLEGE - INSURANCE FORM
GRADUATE STUDENT, SPOUSE AND / OR CHILD COVERAGES**

2009-2010

(Please Print)

STUDENT'S NAME _____ Student I.D. # _____

LOCAL ADDRESS _____

I wish to enroll for the following coverage(s):

- | | | | |
|---|------------------------|---------------------------------------|---|
| <input type="checkbox"/> Student - Basic Coverage | \$430.00 Annual Charge | <input type="checkbox"/> Spouse | <input type="checkbox"/> \$878.00 Annual Charge |
| | | <input type="checkbox"/> All Children | <input type="checkbox"/> \$654.00 Annual Charge |

List Dependents to be insured below:

<u>Last</u>	<u>First</u>	<u>Middle Initial</u>	<u>Date of Birth</u>	<u>Relationship</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Date _____

Signed _____
Student, Parent or Guardian

Return to Hammond Health Center, Ithaca College, 953 Danby Rd., Ithaca, N.Y. 14850