ENSIGN COLLEGE

Away From Campus Coverage/Extended Coverage Request

Student Information:

Name_____

Ensign ID #: _____ Term: _____

Marital Status for Term: ☐ Unmarried ☐ Married

If Married, are you requesting coverage for your spouse? ☐ Yes ☐ No

If unmarried, will you be getting married during the term you are requesting coverage? ☐ Yes ☐ No

☐ **Away-from-Campus Coverage** (Only available if you had DMBA health plan coverage during the previous semester and plan to enroll in at least 9 credits in the upcoming semester. You must pay the standard student rate before the first day of the covered semester. Failure to do so will render you ineligible for this coverage.)

☐ **Graduating Semester Coverage** (If you are graduating and do not need to enroll in 9 or more credits to complete your degree, you may pay the standard student rate for health plan coverage.)

☐ **Less than 9 credit coverage** (Available only if you are enrolled in between 0.5 and 9.0 credits. Please note: this coverage is by request only.)

☐ **Extended Coverage** (Available to graduated students who need to continue coverage for up to 4 consecutive calendar months. You must enroll within 60 days of your last day of coverage.)
Extended payment amount: _____
For dates covering: ____/____/_____ to ____/____/_____
Note: Monthly payments after the first month must be made prior to the next month's coverage. If payments are not received by the due date, coverage will be terminated at the start of the next calendar month.

Student Signature: _____ **Date:** _____
(Please sign by hand—digital signatures will not be accepted)

Posted: ☐ _____

Paid: ☐ _____

Bill Clerk: ☐ _____

Notes:

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