



Student Health Insurance Plan Enrollment Form

International Student

Spouse/Partner/Dependent(s) – Summer 2024

To enroll you must be taking 1 or more credits during the summer session, enrolled in classes for the subsequent fall term, and enrolling in the student insurance plan in the fall.

First & Last Name: _____ WSU ID #: _____

Street Address: _____ Phone #: _____

City, State, Zip: _____ Email: _____

Coverage Selection: Coverage period and premium will depend upon the summer session you are enrolled in.

| Select the coverage that applies to you | May 6, 2024 - July 31, 2024 | June 5, 2024 - July 31, 2024 | June 19, 2024 - July 31, 2024 |
|--|-----------------------------------|-----------------------------------|-----------------------------------|
| Student Coverage | \$626.00 <input type="checkbox"/> | \$410.00 <input type="checkbox"/> | \$309.00 <input type="checkbox"/> |
| Spouse/Domestic Partner Coverage | \$626.00 <input type="checkbox"/> | \$410.00 <input type="checkbox"/> | \$309.00 <input type="checkbox"/> |
| Child(ren) Coverage *The premium is capped at two children for a particular family | 626.00 <input type="checkbox"/> | \$410.00 <input type="checkbox"/> | \$309.00 <input type="checkbox"/> |

Dependent information: Please complete the section below for any spouse/domestic partner, or dependents you want to enroll. To enroll a spouse or domestic partner, ***you must also complete the Declaration of Marriage or Domestic Partnership form.***

| Last Name, First Name, Middle Initial | Date of Birth | Sex | Relationship <small>(husband, wife, domestic partner, son, daughter)</small> |
|---------------------------------------|---------------|-----|---|
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I authorize the enrollment of the coverage(s) marked above. I understand that all coverage changes including cancellation must be processed by the **13th day of classes for Fall and Spring semesters and the 5th day of classes for Summer sessions.**

The non-refundable premium will be charged to my student account based on the coverage information received by the **enrollment deadline on the 13th day of classes for Fall and Spring semesters and the 5th day of classes for Summer sessions.**

Student Signature: _____ Date: _____

Please submit completed form to: Cougar Health Services, Washington Building or mail to PO Box

642302 Pullman, WA. 99164-2302 or email to student.insurance@wsu.edu or fax to (509) 335-8214.