

**2024-2025 DEPENDENT ENROLLMENT FORM**

(For Students of Case Western Reserve University School of Medicine, the Cleveland Clinic Lerner College of Medicine, and Case Western Reserve University School of Dental Medicine - MSD Program)

Student's ID # \_\_\_\_\_

 Student's Name \_\_\_\_\_  
 (Please Print) (First) (Middle) (Last)

 Address \_\_\_\_\_  
 (Street) (City) (State) (Zip Code)

I have purchased Case Western Reserve University Student Medical Plan; I wish to enroll the following members of my family in the Plan.

Eligible dependents of the covered student shall include the spouse or domestic partner and dependent child/ren under the age of 26 years. Newborns must be enrolled within 31 days of birth. Enrollment is not automatic.

<b>Deadline Dates:</b> <b>Fall Semester: 09/06/2024</b> <b>Spring Semester: 01/24/2025</b>	<b>Annual Coverage Dates:</b> <b>7/1/24-6/30/25</b>	<b>Fall Coverage Dates:</b> <b>7/1/24-1/12/25</b>	<b>Spring Coverage Dates:</b> <b>1/13/25-6/30/25</b>
<b>Spouse/Domestic Partner Only</b>	\$3,780	\$1,890	\$1,890
<b>Spouse or Domestic Partner and One Child</b>	\$7,560	\$3,780	\$3,780
<b>Spouse or Domestic Partner and Two or more Children</b>	\$11,340	\$5,670	\$5,670
<b>Child</b>	\$ 3,780	\$1,890	\$1,890
<b>Two or more Children</b>	\$7,560	\$3,780	\$3,780

**NOTE:** Return enrollment form and automatic payment plan form or appropriate check, money order (made payable to Case Western Reserve University) to Case Western Reserve University, 10900 Euclid Ave, Cleveland, OH 44106-4901.

If a student registers after September 6, 2024 for fall semester and after January 23, 2025 for spring semester, the Student Medical Plan will become effective on the date the student registers (not on the effective date listed above).

Medical coverage for spouse/domestic partner and dependent child/ren may not be purchased unless medical coverage for Student is purchased.

Students purchasing dependent coverage for Fall Semester only must submit another enrollment form to renew coverage for Spring/Summer Semesters. In order to maintain continuous coverage payment must be received prior to January 23, 2025.

**Place Dependent Name(s) Below**

1. \_\_\_\_\_ Birth Date \_\_\_\_\_ M/F \_\_\_\_\_  
 Spouse/Domestic Partner (circle one)
2. \_\_\_\_\_ Birth Date \_\_\_\_\_ M/F \_\_\_\_\_  
 Child
3. \_\_\_\_\_ Birth Date \_\_\_\_\_ M/F \_\_\_\_\_  
 Child
4. \_\_\_\_\_ Birth Date \_\_\_\_\_ M/F \_\_\_\_\_  
 Child

 Completion of an Affidavit is necessary for the enrollment of a Domestic Partner. The document is available at the Student Medical Plan department – [medicalplan@case.edu](mailto:medicalplan@case.edu) or (216) 368-3049.