Co-Op Health Plan Opt In

Winter 2017 Application Form

This form will enable you to apply for the FSU Health Plan for the semester by filling in the corresponding application section below. This form must be returned to the FSU Office (SC2001) by the **10th DAY OF THE START OF CLASSES**

(Winter Semester Coverage is January 1st – August 31st, 2017)

STUDENT INFORMATION *(PLEASE PRINT CLEARLY)*

Surname: _____ First Name: _____ Middle Initial: _____

Student ID#: _____ DOB: d/_____ m/_____ y/_____ Gender: M___ F____

Campus: _____ Phone #: _____ Date: _____

Email: _____

OPT IN	**PLEASE ENROLL ME IN THE FOLLOWING: *(to be eligible, all students must have current OHIP or equivalent coverage)*** **Winter Deadline: January 17th, 2017 at 4 p.m.** **I wish to apply for:** **____ $115.00 HEALTH BENEFITS** (indicate by checkmark) (per semester) (tax included) **____ Balanced Plan ____ Enhanced Dental Plan ____ Enhanced Drug/EHC Plan** (indicate by checkmark) I wish to apply for the Fanshawe Student Union Health Plan and agree to be bound by the benefit plan terms and conditions. **Payment: CASH, DEBIT and CREDIT to Fanshawe Student Union** **(Return form & money to the FSU Office, SC 2001)** **Hours: Monday-Friday 9:00am-4:30pm** SIGNATURE OF STUDENT _____