University of Idaho
Student Health Insurance Program

SHIP Dependent Enrollment

THIS FORM MUST BE COMPLETED EVERY SEMESTER IN WHICH YOU WISH TO HAVE DEPENDENT COVERAGE.

STUDENT NAME: _____

VANDAL ID #: _____

VANDAL EMAIL: _____ @vandals.uidaho.edu

DATE OF BIRTH: _____

ADDRESS: _____

I AM ENROLLING MY DEPENDENT(S) FOR THE FOLLOWING SEMESTER:

- ◯ Fall 2026
- ◯ Spring 2027
- ◯ Summer 2027

COST FOR DEPENDENT(S) PER SEMESTER	
SPOUSE	$1,171.50
CHILD	$1,171.50
2 OR MORE CHILDREN	$2,343.00
SPOUSE + 2 OR MORE CHILDREN	$3,514.50

DEPENDENT(S) INFORMATION:

LAST NAME	FIRST NAME	DATE OF BIRTH	LEGAL SEX	RELATIONSHIP TO STUDENT

STUDENT SIGNATURE: _____ **DATE:** _____

Deliver to: Student Health Building Room 101 **Email:** studentinsurance@uidaho.edu
Mail: 875 Perimeter Dr MS 4203, Moscow, ID 83844