Gallagher | STUDENT HEALTH & SPECIAL RISK

Petition to Add Coverage – Student Health Insurance Plan (SHIP) – Dependents

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY IN ORDER TO BE CONSIDERED

Please print clearly to ensure accurate processing

If you are a currently enrolled, or are Petitioning to Add coverage for yourself, under the SHIP and your dependent experiences a Qualifying Event (QE), you may complete this Form requesting to add him/her to the SHIP. You must provide documentation of the QE and submit it with this completed form within 30 days of the QE. Forms received more than 30 days after the QE will not be processed.

Name of School: _____ Date: _____

Student Name: _____ _____ _____
Last First Middle Initial

Student ID#: _____ Male: ☐ Female: ☐ Date of Birth: ____/____/_____
MM DD YYYY

Phone Number: _____ Email Address: _____

Coverage can only be added if there is a Qualifying Event (QE). A QE is defined as:

- Reaching the age limit of another health insurance;
- Adoption, Birth, Marriage, or Divorce; or
- Involuntary loss of coverage from another health insurance.

Please provide detail on the circumstances of the QE and reason for this request.

_____

_____

_____

Dependent Information				
First Name	**Last Name**	**Date of Birth**	**Gender**	**Spouse or Child**

Notice to Students: I understand this Petition is subject to the approval of Gallagher Student Health & Special Risk (GSH) and the payment of any applicable premium. The effective date of coverage will determine premium due. **Please contact GSH to determine premium due.** Once the petition and payment have been processed, coverage cannot be cancelled, except for eligibility reasons or as specifically stated in the policy.

All required documentation must be included. Forms without supporting documentation of the QE will not be processed.

In order to not have a lapse in coverage, this form and supporting documentation must be received by GSH within 30 days of the QE. If this form and supporting documentation are not received within 30 days, the form will not be processed.

By signing below, the student acknowledges the following: 1) I have carefully read the brochure and elect to enroll my dependent(s) as indicated on this form. 2) I meet the eligibility requirements for this coverage as described in the plan materials.

Signature of Student: _____ Date: _____

Student being enrolled must sign form in order to be processed.

****A $15 processing fee applies to all transactions****

PAYMENT INSTRUCTIONS: Charge to my (check one): ☐ Visa ☐ Master Card

Card Number: _____ Amount Charged: $_____ Expiration Date: _____

Name and Address of Card holder_____

Check or money order (International checks are not accepted): Make check or money order payable to **Gallagher Student Health & Special Risk**. Email or mail enrollment form along with premium payment to: Gallagher Student Health & Special Risk
Mail: P.O. Box 845663, Boston MA 02284-5663 Email: enrollmentteam@gallagherstudent.com

To be completed by Gallagher Student Health

_____ Approved _____ Denied Date: _____ Effective Date: _____ Initials:_____