Gallagher | STUDENT HEALTH & SPECIAL RISK

NEW YORK REQUEST TO TERMINATE STUDENT HEALTH INSURANCE COVERAGE

This form must be completed entirely to ensure proper processing

Policy: If you are currently enrolled in the Student Health Insurance Plan (SHIP) sponsored by your institution located in the state of New York, you can request a termination of coverage. Your institution requires you to have active and comparable health insurance coverage. Therefore in order for your request to terminate to be approved, you must document proof of enrollment in a health insurance plan in the section below. This is NOT a full-waiver. If approved, you will only be receiving a partial refund of the student medical insurance premium.

Procedure for Students:

- Complete the 'Contact Information' section of the form.
- Complete the 'Reason for Termination' section in its entirety. Forms with missing or incomplete information will not be processed.
- Submit the form and a verification of coverage letter from your other insurance company to GSH via email (enrollmentteam@gallagherstudent.com). Students will be notified via email the status of their request within 7-10 business days.

Contact Information:

Name of School: _____Domestic or International Student_____

Name: _____ _____ Student ID #:_____
(Last) (First)

Address: _____

Date of Birth: ____/_____/_____ Phone: (____) _____ Email: _____

THIS SECTION MUST BE COMPLETED

Reason for Termination: Please Select One

____I have graduated from or have permanently withdrawn from the University. (Students going home for school breaks are still considered students of the University and are not eligible to request termination for this reason.)

Date of withdrawal*: ____/_____/_____ Date of graduation: ____/_____/_____

OR

____I have other insurance coverage which provides comparable coverage

Please provide information on the health insurance plan with which you are substituting your current SHIP as well as a copy of your ID card. Once this information is confirmed, your termination date will be the last day of the month during which this request is received.

Name of Insurance Company: _____

Address of Insurance Company: _____

Customer Service Phone #: (____) _____ Subscriber ID: _____

Type of Plan: HMO ___PPO ___ POS ___ Medicaid ___ Indemnity ___ VA/Military ___Medicare ___

Subscriber Name: _____ Relationship to Insured: _____

Effective Date of Insurance Coverage: ___/____/_____ (There cannot be a break between the Student Health Insurance Plan and the insurance company listed on this form.)

Refund Acknowledgment:

By initialing here, I understand that I am completing an early termination, NOT a full-waiver. I will only be receiving a partial refund of the student medical insurance premium: _____

By submitting this Request, I certify that:

1. I am currently covered and will continue to be covered throughout the year by the insurance company listed above.
2. I have compared my current coverage with the school-sponsored plan and have determined them to be comparable.
3. I understand that if this request is approved, I cannot enroll in the school's student insurance plan until the next policy year.
4. I am responsible for the full cost of any medical claims that may be incurred after the date of termination.
5. I certify that the above information is true and accurate.

Please email the completed form and required documentation to enrollmentteam@gallagherstudent.com.

Signature _____ Date_____/_____/_____