Gallagher | STUDENT HEALTH & SPECIAL RISK

Johns Hopkins University – School of Nursing
Request to Change Enrollment Status

Student Name_____
Last First Initial

Student ID #_____ **Date of Birth** _____/_____/_____
MM DD YYYY

Phone Number_____ **Email Address** _____

THIS FORM WILL CHANGE INSURANCE SELECTIONS PREVIOUSLY SUBMITTED

Please complete the plan section(s) below as applicable to your needs. There are two sections: **I)** Enrollment/Termination Request for Johns Hopkins EHP **II)** Enrollment/Termination Request for EHP COBRA. Check no more than one box for each insurance product. Please also add the dates of a Qualifying Life Event (QLE) in boxes labeled (mm/dd/yyyy).

Once this form is complete, sign it and return to the website to upload this form and the appropriate supporting documentation. To upload, use the CustomerService link under Student Access. From the "Choice Help Topic" dropdown menu, select "Change Enrollment Choices".

Note: **When uploading, please attach the completed form AND proof of Qualifying Life Event (QLE) or proof of loss of coverage letter from prior health insurance carrier.**

I. Johns Hopkins EHP (Health Insurance)

Enrollment Request

☐ **I am not currently enrolled in EHP and have experienced a Qualifying Life Event (QLE) on** mm/dd/yyyy **and want to enroll myself and my dependents (if applicable) in EHP. I understand the effective date of coverage in EHP will be the day of the Qualifying Life Event (QLE).**

Check one and upload proof of Qualifying Life Event (QLE) (and provide applicable documentation):

- ☐ My change in student status now requires me to have health insurance.
- ☐ Change in marital status (marriage certificate)
- ☐ Birth or adoption of child(ren) (birth/adoption certificate)
- ☐ Loss of existing health coverage (document from prior carrier of loss of coverage)
- ☐ Judgment/decree/order requiring me to provide health insurance coverage for my dependent (court order).

If enrolling dependents, provide the following information:

Dependents	First Name	M. I.	Last Name	Gender	Date of Birth
Spouse					
Child					
Child					
Child					

☐ **I am currently enrolled in EHP and I want to add the following dependents due to a Qualifying Life Event on** mm/dd/yyyy **. I understand the effective date of coverage in EHP will be the day of the Qualifying Life Event (QLE).**

Check one and upload proof of Qualifying Life Event (QLE):

- ☐ Change in marital status (marriage certificate)
- ☐ Birth or adoption of child(ren) (birth or adoption certificate)
- ☐ Loss of dependent's existing health coverage (document from prior carrier of loss of coverage)
- ☐ Judgment/decree/order requiring me to provide health insurance coverage for my dependent (judge or court decree)
- ☐ Dependent arrival in United States (flight itinerary or plane ticket)
- ☐ Other: _____

To enroll dependents, provide the following information:

Dependents	First Name	M. I.	Last Name	Gender	Date of Birth
Spouse					
Child					
Child					
Child					

Termination Request

☐ **I am currently enrolled in EHP and am requesting a termination of coverage due to a Qualifying Life Event (QLE) on** mm/dd/yyyy **. I understand the termination of my coverage will also terminate coverage for any dependents currently enrolled as of this same day and that my coverage will end on the last day of the month of the Qualifying Life Event (QLE).**

Check one and upload proof of Qualifying Life Event (QLE):

- ☐ I have enrolled in other comparable health insurance
- ☐ Other _____

☐ **I am currently enrolled in EHP and am requesting a termination of coverage for the following dependent(s) on the last day of** mm/yyyy **. My EHP coverage will not be terminated.**

To terminate dependents, provide the following information:

Dependents	First Name	M. I.	Last Name	Gender	Date of Birth
Spouse					
Child					
Child					
Child					

Johns Hopkins EHP (COBRA)

☐ **I am currently enrolled in EHP COBRA coverage and am requesting a termination of COBRA coverage on last day of** mm/yyyy **. I understand by terminating my COBRA coverage, it will also terminate COBRA coverage for my dependents (if applicable). I further understand once COBRA coverage is terminated, there is no opportunity to re- enroll in COBRA.**

☐ **I am currently enrolled in EHP COBRA coverage and want terminate my COBRA coverage for the listed dependents onlast day of** mm/yyyy **. I understand once my COBRA coverage is terminated, there is no opportunity to re-enroll my dependents in COBRA. My COBRA coverage will not be terminated.**

Dependents	First Name	M. I.	Last Name	Gender	Date of Birth
Spouse					
Child					
Child					
Child					

Notice to Students: 1) Any change indicated on this form will be effective on the dates described above; 2) If enrolling, the student confirms they have carefully read the applicable plan documents brochure and elects to enroll as indicated on this enrollment form; 3) Any applicable premium will be billed to the student's bursar account; 4) Enrolled Student meets the eligibility requirements for this coverage as described in the brochure. 5) If it is later determined that the student is not eligible, the premium will be refunded. 6) Other than for eligibility reasons, the premium is not refundable.

Signature of Student: _____ Date: _____
(enter either your electronic signature or type in your full name)

Next Step: Once this form is complete, sign it and return to the website to upload this form. To upload, use the Customer Service link under Student Access. From the "Choice Help Topic" dropdown menu, select "Change Enrollment Choices".

Note: **When uploading, please attach the completed form AND proof of Qualifying Life Event (QLE) or proof of loss of coverage letter from prior health insurance carrier.**

Proof of Qualifying Life Events include (but are not limited to) the following:

- Change in marital status **– please include marriage certificate**
- Birth or adoption of child **– please send birth or adoption certificate**
- Loss of existing health coverage **–please include letter from prior carrier regarding loss of coverage**
- Enrollment in other insurance **–please include Verification of Coverage letter, with effective dates, and plan description.**