



Johns Hopkins University - Bloomberg School of Public Health

Request to Change Enrollment Status

Student Name \_\_\_\_\_
Student ID # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_
Phone Number \_\_\_\_\_ Email Address \_\_\_\_\_

IF APPROVED, THIS FORM WILL CHANGE INSURANCE SELECTIONS PREVIOUSLY SUBMITTED
\*Please note, form must be submitted within 30 days of the Qualifying Life Event.

Please complete the plan section(s) below. There are two sections: I) Enrollment/Termination Request for Johns Hopkins EHP and II) Termination Request for EHP COBRA. Check no more than one box for each insurance product.

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" drop down menu, select "Change Enrollment Choices".

I. Johns Hopkins EHP (Health Insurance)

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

Check one and upload proof of QLE:

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

Provide the following information:

Table with 6 columns: Dependents, First Name, M. I., Last Name, Gender, Date of Birth. Rows include Spouse and three Child entries.

I am not currently enrolled in EHP and have experienced a Qualifying Life Event (QLE) on \_\_\_\_\_ 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 QLE.

**Check one and upload proof of QLE:**

My change in student status now requires me to have health insurance (Gallagher will validate the status change with JHU-BSPH).

Change in marital status (marriage certificate)

Birth or adoption of child(ren) (birth or adoption certificate)

Loss of existing health coverage (document from prior carrier of loss of coverage)

Dependent arrival in United States (flight itinerary or plane ticket)

Judgment/decreed/order requiring me to provide health insurance coverage for my dependent.

Other:

**To enroll dependents, provide the following information:**

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

**Johns Hopkins EHP (Health Insurance) – Termination Request**

I am currently enrolled in EHP and am requesting a termination of coverage due to a Qualifying Life Event on \_\_\_\_\_. I understand the termination of my coverage will also terminate coverage on the same day for any currently enrolled dependents.

I have experienced the following QLE or other reason (check one and upload proof of QLE and other coverage where appropriate):

My change in student status does not require me to have health insurance (Gallagher will validate the status change with JHU-BSPH)

I have enrolled in other comparable health insurance (verification of coverage letter from other insurance company)

Other:

I am currently enrolled in EHP and am requesting a termination of coverage for the following dependent(s) on the last day of \_\_\_\_\_. 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					

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## II. Johns Hopkins EHP (COBRA)

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I am currently enrolled in EHP COBRA coverage and am requesting a termination of COBRA coverage on the last day of \_\_\_\_\_. I understand that by terminating my COBRA coverage, any COBRA coverage for my dependents will also end. I understand once COBRA coverage is terminated, there is no opportunity to re-enroll.

I am currently enrolled in EHP COBRA coverage and want to terminate COBRA for the listed dependents on the last day of \_\_\_\_\_. I understand once 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 SIS 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: \_\_\_\_\_  
(enter either your electronic signature or type in your full name)

Date: \_\_\_\_\_

**Next Step:** Once this form is completed, please return to the website and upload this form and supporting documentation using the Customer Service Link under Student Access. From the 'Choice Help Topic' drop down menu, select 'Change Enrollment Choices'.