University of West
Travel Assistance, Medical Evacuation and Repatriation of Remains Benefits
2014-2015 Policy Year Enrollment Form

(Please Print)
Student Name_____
Family/Last First Initial
Permanent US Address_____
Street or P.O. Box City State Zip Code
Student ID #_____ Male_____ Female_____ Date of Birth _____/_____/_____
MM / DD / YYYY
Phone Number_____ Email Address_____

Eligibility	Program Fee	Premium Payment
Primary Insured	$50	
Spouse	$50	
Each Child	$50	
	Total Payment	

This form and required premium is enrolling you and/or your dependents for up to $250,000 Medical Evacuation, $50,000 Repatriation of Remains, $100,000 Political Evacuation, $100,000 Natural Disaster Evacuation, a 24 hour Nurse-line, and Worldwide Emergency Travel Assistance.

List Dependent(s) to be insured below. Dependent coverage is available only when the student is also insured under this plan and cannot exceed coverage purchased by the student. Dependents need to be enrolled within 30 days from the effective date for the period of coverage selected. In the event of a qualifying event (i.e. birth of child, marriage, etc.), this Dependent Enrollment form and payment must be received by Gallagher Student Health & Special Risk within 31 days of the qualifying event. There is no pro-rata of premium. Once a Dependent is enrolled, coverage cannot be terminated unless the student loses eligibility.

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

Notice to Students:
Coverage will be effective the first date of the Coverage Period when the correct premium is received by Gallagher Student Health & Special Risk by the Enrollment Deadline; Enrollment Forms will not be accepted after the Enrollment Deadline has passed. It is the student's responsibility for timely renewal payment. By signing below, the student acknowledges the following: 1) He/She has carefully read the Benefits, Exclusions and Limitations document and elects to enroll as indicated on this enrollment form. 2) Rates are not prorated other than as listed on this enrollment form. 3) Enrolled Dependent meets the eligibility requirements for this coverage as described in the brochure. 4) If it is later determined that the student is not eligible, the premium will be refunded. 5) A Dependent cannot be insured under this Plan if the Insured Student loses eligibility under the Student Injury and Sickness Insurance Plan. 6) Other than for eligibility reasons, the premium is not refundable.

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

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

Print 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**. Mail or fax enrollment form along with premium payment to:
Gallagher Student Health & Special Risk, P.O. Box 845663, Boston, MA 02284-5663 or fax: (617) 479-0860

You must be eligible to enroll in the Plan and meet the enrollment deadline in order for your enrollment to be accepted by us. If it is discovered that you do not meet the requirements, your premium will be refunded. Questions regarding the enrollment process please contact Gallagher Student Health & Special Risk at (877)-540-7407.