PURMIT Study Abroad
Leisure Travel Insurance Enrollment Form

(Please Print)

Insured's Name____
Last First Initial

Permanent US Address____
Street or P.O. Box City State Zip Code

Phone Number______________________________ Email Address__________________________________

Insurance ID#______________________________ Male______ Female______ Date of Birth _____/_____/_____
MM / DD / YYYY

Travel Dates_____________________ to _______________________ Destination_____________________________

(You cannot enroll past 05/31/2018)

	Daily Rate
Insured	$3
Spouse	$3
Each Child	$3

List Dependent(s) to be insured below. Dependent coverage is available only when the Oregon State University student, faculty or staff is also insured under this plan. Dependent enrollment must coincide with the travel dates of the Primary Insured. Coverage must be purchased by the departure date. Once a dependent is enrolled, coverage cannot be terminated unless the Insured loses eligibility.

	Last Name	First Name	MI	Date of Birth
Spouse:	____________	____________	_____	____________
Child:	____________	____________	_____	____________
Child:	____________	____________	_____	____________
Child:	____________	____________	_____	____________

Notice to Insureds:
Coverage will be effective the date the correct premium is received by Gallagher Student or the effective date of the coverage period, whichever is later. It is the Insured's responsibility for timely renewal payment. By signing below, the Insured acknowledges the following: 1) He/She has carefully read the brochure 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 Primary Insured loses eligibility under the Oregon University System Study Abroad Accident and Sickness Insurance Plan. 6) Other than for eligibility reasons, the premium is not refundable.

Signature of Insured:____ **Date:**__________________________

PAYMENT INSTRUCTIONS: Please include an additional $10.00 processing fee with your enrollment.
Charge to my (check one): __ Visa __ Master Card __ Check or money order (International checks are not accepted)

Card Number: ____________________________________ Amount Charged: $_____________ Expiration Date: ______________

Print Name and Address of Card holder____

Make check or money order payable to **Gallagher Student**. Mail or Fax enrollment form along with premium payment to:
Gallagher Student, **P.O. Box 845663, Boston, MA 02284-5663 or Fax: 1-617-479-0860**

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.