University of Central Florida Hardwaiver Plan
Petition to Add Student ONLY Form

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY IN ORDER TO BE REVIEWED

Eligibility: All International students with a current passport and student visa (F1 or J1) are eligible to purchase the UCF-endorsed Student Injury and Sickness Insurance Plan. Medical students, Practical Training Students and Post-Doctoral Visiting Scholars are eligible to enroll.

Please print clearly to ensure accurate processing. **Date_____**

Student's Name_____ **Student ID Number_____**

Address_____Gender □**Male** □ **Female**
Street or P.O. Box City State Zip

Date of Birth_____ Telephone # _____ Email_____

Student Status: □ **International /** □ **Domestic** **Student Status _____**

Name of Individual Completing Form_____ Relationship to Student _____

Dates of Coverage	**Annual** (8/15/12-8/14/13)	**Fall** (8/15/12-12/31/12)	**Spring/Summer** (1/1/13-8/14/13)	**Summer** (5/1/13-8/14/13)
Student Rate	$1,537	$585	$952	$446

Students can only add coverage if there is a qualifying event. A qualifying event is defined as:

- ✓ Reaching the age limit of another health insurance plan
- ✓ Loss of health insurance through a marriage or divorce
- ✓ Involuntary loss of coverage from another health insurance plan

Please detail your extenuating circumstances explaining the reason you wish to enroll yourself:

_____

_____

_____

I understand this Petition is subject to the approval of Gallagher Koster and subject to the payment of any applicable premium.

If you are completing this petition as a result of losing coverage under your previous insurance carrier, for whatever reason, you must include a letter from your previous carrier confirming loss of coverage and indicating the last date of coverage. In order not to have a lapse in coverage, this petition must be received within 31 days of your last day of coverage. If this form is not received within 31 days of your last day of coverage, the effective date will be the date that this form is received at Gallagher Koster.

_____ _____

Signature of Person Completing Form **Date**

Please complete form and return it <u>with payment and a letter from your previous carrier confirming loss of coverage to</u>: Gallagher Koster, 500 Victory Road, Quincy, MA 02171 or fax 617-479-0860

To enroll your eligible dependent, download and complete a dependent enrollment form at: www.gallagherkoster.com\ucf

<u>PAYMENT INSTRUCTIONS: Please add $10 processing fee.</u>

Charge to my (check one): ___ Visa ___ Master Card ___Discover 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 Koster**. **____Enclosed is my check for** $_____

To be completed by Gallagher Koster

□Approved/ □Denied Date _____ Effective Date_____Initials_____