



Vanderbilt University Student Insurance Dependent Petition to Add Form

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

Please print clearly to ensure accurate processing.

Date _____

Student's Name _____ Student ID Number _____

Date of Birth _____ Telephone # _____ Email _____

Dependent Name 1: _____ Date of Birth _____

Gender _____ Male _____ Female Dependent Type: _____ Spouse _____ Child

Dependent Name 2: _____ Date of Birth _____

Gender _____ Male _____ Female Dependent Type: _____ Spouse _____ Child

Dependent Name 3: _____ Date of Birth _____

Gender _____ Male _____ Female Dependent Type: _____ Spouse _____ Child

Name of Individual Completing Form _____
(if other than student)

Relationship to Student _____

Dependent coverage can only be added if there is a qualifying event. A qualifying event is defined as:

- ✓ Reaching the age limit of another health insurance plan
- ✓ Adoption, Birth, Marriage or Divorce
- ✓ Involuntary loss of coverage from another health insurance plan

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

I understand that this Petition is subject to the approval of Gallagher Student Health & Special Risk and subject to the payment of any applicable premium. Once your petition has been processed, it cannot be cancelled, except for eligibility reasons.

If you are completing this petition as a result of your dependent losing coverage under your previous insurance carrier, for whatever reason, you must include a letter from the 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 the last day of coverage. Forms received more than 31 days after the qualifying event will not be processed.

Signature of Person Completing Form

Date

Please complete form and return it with a letter from your previous carrier confirming loss of coverage to:
Gallagher Student Health & Special Risk, 500 Victory Road, Quincy, MA 02171 or fax 617-479-0860

To be completed by Gallagher Student Health & Special Risk

____ Approved/ _____ Denied Date _____ Effective Date _____ Initials _____

Vanderbilt University

2015-2016 Policy Year Dependent Petition to Add Form

Premium Calculation Reference Sheet

If you are a currently enrolled in the Vanderbilt University Student Health Insurance Plan and your dependent experiences a qualifying event, then you may complete this Petition to Add application requesting to add him/her to the Student Health Insurance Plan. You must provide documentation of the qualifying event and submit it with this completed form and applicable payment to Gallagher Student Health & Special Risk within 31 days of the qualifying event. Forms received more than 31 days after the qualifying even will not be processed. Once the premium is received, coverage will be activated and will remain effective until the end of the policy year. **The required premium must be received by Gallagher Student Health & Special Risk in order to activate the coverage.**

Other than for newborns, the **premium is not prorated.** If you are enrolling a newborn, please contact Gallagher Student Health & Special Risk for the applicable premium.

Please refer to the below to determine the insurance premium. Indicate the date of the qualifying event and circle the applicable premium below. **Date of Qualifying Event on:**_____.

Undergraduate Dates of Coverage	Annual (8/12/15-8/11/16)	Spring (1/1/16-8/11/16)	May Mester (5/1/16-8/11/16)	Summer (6/1/16-8/11/16)	Total Premium
Last date of Coverage	8/12/15 - 12/31/15	1/1/16 - 4/30/16	5/1/16 - 5/31/16	6/1/16 - 8/11/16	
Spouse/Domestic Partner	\$2,054	\$1,257	\$578	\$404	
Each Child	\$2,054	\$1,257	\$578	\$404	
All Children	\$4,108	\$2,514	\$1,156	\$808	
All Dependents	\$6,162	\$3,781	\$1,734	\$1,212	
Processing Fee					\$10.00
Total Payment Amount (Premium plus Processing Fee)					

Graduate/International Dates of Coverage	Annual (8/12/15-8/11/16)	Spring (1/1/16-8/11/16)	May Mester (5/1/16-8/11/16)	Summer (6/1/16-8/11/16)	Total Premium
Last date of Coverage	8/12/15 - 12/31/15	1/1/16 - 4/30/16	5/1/16 - 5/31/16	6/1/16 - 8/11/16	
Spouse/Domestic Partner	\$2,706	\$1,655	\$762	\$533	
Each Child	\$2,706	\$1,655	\$762	\$533	
All Children	\$5,412	\$3,310	\$1,524	\$1,066	
All Dependents	\$8,118	\$4,965	\$2,286	\$1,599	
Processing Fee					\$10.00
Total Payment Amount (Premium plus Processing Fee)					

PAYMENT INSTRUCTIONS:

Charge to my (check one): _____ Visa _____ Master Card

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

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
Fax: 617-479-0860