Student Insurance Petition to Add Student ONLY Form

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

Please print clearly to ensure accurate processing. **Date:** ______________________________

Name of College or University: ____

Student's Name: ____________________________________ **Student ID Number:** ___________________________

Address: ____ ______________________ __________ _______________

Street or P.O. Box City State Zip

Gender: _____ **Male** _____ **Female** **Date of Birth:** ________________ **Telephone #:** ______________________

Email: ____ **Student Status:** _____ **International** _____ **Domestic**

Class Level: _____ **Undergraduate** _____ **Graduate** _____ **Law** _____ **Medical**

Name of Individual Completing Form: ____

(if other than student)

Relationship to Student: ____

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:

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I understand that this Petition is subject to the approval of Gallagher Student Health and subject to the payment of any applicable premium. Effective date of coverage will determine premium due. Please see brochure coverage period rates. Premium is not pro-rated. Once your petition has been processed, coverage cannot be cancelled, except for eligibility reasons.

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 Student Health.

____ ___________________

Signature of Student *(student being enrolled must sign form in order to be processed)* **Date**

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

To enroll your Dependents please contact Gallagher Student Health & Special Risk Customer Service.

To be completed by Gallagher Student Health

_____ Approved _____ Denied Date: _____________ Effective Date: ___________ Initials:_____________