Hofstra University
Student Health Insurance Plan
2015-2016 Petition to Add for International /Medical Students

(Please Print)

Student Name_____ _____ _____
Last First Initial

Local Address_____ _____ _____ _____
Street City State Zip

Student ID#_____ Male_____ Female_____ Date of Birth _____/_____/_____
MM D D YYYY

Phone Number_____ Email Address_____

Students who wish to enroll in the Hofstra University Student Health Insurance Plan after the enrollment deadline can only add coverage if there is a qualifying event. A qualifying event is defined as:

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

Please detail your extenuating circumstances explaining the reason you which to enroll yourself.

_____
_____
_____

Enrollment Period: Please indicate the coverage period you are requesting enrollment for:

Dates of Coverage	**Fall** (08/1/15 - 12/31/15)	**Spring/Summer** (1/1/16 - 7/31/16)	**Total Premium**
Previous coverage ended between:	08/1/15 - 12/31/15	1/1/16 - 7/31/16	
Student Rate	$533	$746	
Processing Fee			$10.00
Total Due:			

Notice to Students: I understand that this Petition is subject to the approval of Gallagher Student Health & Special Risk and the payment of any applicable premium. I am completing this petition as a result of losing coverage under my previous insurance carrier due to a qualifying event and must include a letter from my previous carrier confirming loss of coverage and the last date of coverage.

In order to not have a lapse in coverage, this petition must be received by Gallagher Student Health & Special Risk within 31 days of the last day of my previous coverage. If this form is not received within 31 days of the last day of my previous coverage, the effective date will be the date this form is received by Gallagher Student Health & Special Risk.

By signing below, the student 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) He/She 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) Other than for eligibility reasons, the **premium is not refundable**.

Signature of Student: _____ Date: _____

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

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**

Prepared by Gallagher Student Health & Special Risk
December 2015