Gallagher | STUDENT HEALTH & SPECIAL RISK

2016-2017 Quinnipiac University Petition to Add Full-time Undergraduate & Graduate Students

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

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_____

Enrollment Period	Plan period	Premium
Annual Undergraduate	08/15/2016-08/14/2017	$2,150
Annual Graduate	08/15/2016-08/14/2017	$2,450
Spring/Summer Undergraduate	01/01/2017-08/14/2017	$1,317
Spring/Summer Graduate	01/01/2017-08/14/2017	$1,511
Summer Undergraduate	05/15/2017 – 08/14/2017	$533
Summer Graduate	05/15/2017 – 08/14/2017	$625
	Processing Fee (non-refundable)	$10
	Total Payment Submitted	$

Students can only add coverage if there is a qualifying event. Please check qualifying event:

__ 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

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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.

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 & Special Risk.

Please complete form with payment and return it <u>with a letter from your previous carrier confirming loss of coverage to</u>:

Gallagher Student Health & Special Risk
P.O. Box 845663
Boston MA 02284-5663
Fax: 617-479-0860

PAYMENT INSTRUCTIONS:
Charge to my (check one): ___ Visa ___ Master Card
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 Student Health & Special Risk**

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.