

Petition to Add Frequently Asked Questions

Please read the information below carefully before completing a Petition to Add form.

If I lose coverage under another insurance policy, can I enroll in the school's plan?

Yes, if you waived the Student Health Insurance Plan and then lose coverage under that plan due to a qualifying event (see specific question below) you may submit a Petition to Add form. Make sure you read the form carefully as it contains very specific information on the Petition to Add process, including required documentation to show proof of loss. We will need to confirm your plan eligibility with your school before processing your request. Petition to Add forms are processed within 5-7 business days after confirming plan eligibility with your school.

Am I eligible to Petition to Add?

You need to meet the definition of your plan's eligibility statement which you can find in your school's FAQ or in the plan brochure. To access these documents, click the "My Benefits and Plan Information" located on the left-hand side of this homepage.

Students who enroll on a voluntary basis are not eligible to petition to add and will need to wait until the enrollment period for the next plan coverage period in order to purchase coverage.

What is considered a qualifying event?

- Reaching the age limit of another health insurance plan (**Example: Turning Age 26**)
- Loss of health insurance through a marriage or divorce
- Involuntary loss of coverage through my parents health insurance plan
- Involuntary loss of coverage through my employer

What other information do I need to submit with the Petition to Add form?

You must include documentation from your insurance company (for example a letter on the company's letterhead or Confirmation of Coverage form) confirming your loss of coverage and indicating your last date of coverage. The following are supporting documentation requirements:

- Must have the student's full name
- Must have the last date of your coverage (termination date)
- COBRA eligibility letters can only be accepted if the letter states the student's full name and termination date. **A COBRA letter is not an official termination letter. COBRA eligibility letters are sent to you prior to losing coverage.**

Also please note the following:

- Supporting documents need to be in pdf format; they cannot be in Word doc or email format for authenticity reasons.
- Screenshots will not be accepted.

Will I have a break in coverage?

You will not have a break in coverage if the Petition to Add form and applicable documents are received within 30 days of your qualifying event. If the Petition to Add form and required documentation are not received within 30 days of your qualifying event, the effective date will be the date this form and applicable documentation are received at Gallagher Student Health.

Will the premium be pro-rated?

Yes, the premium you pay will be pro-rated on a monthly basis determined by the date of your Qualifying Event.



University of South Florida Student Health Insurance Plan 2018-2019 Petition to Add – Mandated Plan

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

(Please Print)

Student Name _____
Last First Initial

Address _____
Street or P.O. Box City State Zip Campus

Student ID# _____ Male _____ Female _____ Date of Birth ____/____/____
MM DD YYYY

Phone Number _____ Email Address _____

Please check all that apply: ☐ Domestic ☐ International

☐ Undergraduate ☐ Graduate ☐ Department Payee ☐ College of Marine Science ☐ USF Wellness Employee

☐ College of Medicine ☐ OPT/CPT ☐ College of Pharmacy ☐ Intercollegiate Athlete ☐ Program Mandated Student

Students who wish to enroll in the University of South Florida 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 wish to enroll yourself.

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

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 also understand that Gallagher Student Health & Special Risk will confirm my eligibility with the College before my petition request is processed. If it is discovered that you do not meet eligibility requirements, this form will not be processed and your premium will be refunded.

In order to not have a lapse in coverage, this petition and payment must be received by Gallagher Student Health & Special Risk within 31 days of the last day of previous coverage. If this form and payment are not received within 31 days of the last day of 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: _____

Determining your premium payment: Please refer to the following premium calculation sheet to determine the insurance premium amount you are required to submit with this Petition to Add form.

PAYMENT INSTRUCTIONS: Please add \$15 credit card processing fee

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 email enrollment form along with premium payment to: **Gallagher Student Health & Special Risk, P.O. Box 845663, Boston, MA 02284-5663 / E-mail:**

enrollmentteam@gallagherstudent.com

University of South Florida

Petition to Add – Mandated/Supported

2018-2019 Premium Calculation Reference Sheet

These premiums are applicable to the following group of students: International Students, INTO USF students, Department Payees, Intercollegiate Athletes, USF Wellness Employees, College of Medicine, OPT/CPT, College of Marine Science, College of Pharmacy and program Mandated students.

If you experience a qualifying event in which you lost your other medical insurance coverage, then you may complete this form requesting to be added to the Student Injury and Sickness Insurance Plan. You must provide documentation of the loss of coverage and submit it with this completed form and applicable payment to Gallagher Student Health & Special Risk within 31 days of the qualifying event. If the 31 day deadline is missed, you will not be able to enroll until the next open enrollment period. Once the premium is received, coverage 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.**

Please refer to the below schedule to determine your insurance premium. Mark the correct checkbox to indicate the last date of prior insurance coverage.

Last Date of Coverage between	✓ Check	Premium Due
8/17/18 and 9/16/18		\$2,403
9/17/18 and 10/16/18		\$2,204.62
10/17/18 and 11/16/18		\$2,004.20
11/17/18 and 12/16/18		\$1,803.78
12/17/18 and 1/16/19		\$1,603.36
1/17/19 and 2/16/19		\$1,402.94
2/17/19 and 3/16/19		\$1,202.52
3/17/19 and 4/16/19		\$1,002.10
4/17/19 and 5/16/19		\$801.68
5/17/19 and 6/16/19		\$601.26
6/17/19 and 7/16/19		\$400.84
7/17/19 and 8/16/19		\$200.42

**Petition to Add Coverage – Student Health Insurance Plan (SHIP) – Dependents****THIS FORM MUST BE COMPLETED IN ITS ENTIRETY IN ORDER TO BE CONSIDERED****Please print clearly to ensure accurate processing**

If you are a currently enrolled, or are Petitioning to Add coverage for yourself, under the SHIP and your dependent experiences a Qualifying Event (QE), you may complete this Form requesting to add him/her to the SHIP. You must provide documentation of the QE and submit it with this completed form within 31 days of the QE. When you have a newborn or adopt a child and we are notified within 31 days, coverage for the child starts at the moment of birth or adoption. Otherwise, coverage begins on the date we receive notice.

Name of School: _____ Date: _____

Student Name: _____
Last First Middle InitialStudent ID#: _____ Male: ☐ Female: ☐ Date of Birth: ____/____/____
MM DD YYYY

Phone Number: _____ Email Address: _____

Coverage can only be added if there is a Qualifying Event (QE). A QE is defined as:

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

Please provide detail on the circumstances of the QE and reason for this request.

Dependent Information				
First Name	Last Name	Date of Birth	Gender	Spouse or Child

Notice to Students: I understand this Petition is subject to the approval of Gallagher Student Health & Special Risk (GSH) and the payment of any applicable premium. The effective date of coverage will determine premium due. **Please contact GSH to determine premium due.** Once the petition and payment have been processed, coverage cannot be cancelled, except for eligibility reasons or as specifically stated in the policy.

All required documentation must be included. Forms without supporting documentation of the QE will not be processed.

In order to not have a lapse in coverage, this form and supporting documentation must be received by GSH within 31 days of the QE. If this form and supporting documentation are not received within 31 days, the form will not be processed.

By signing below, the student acknowledges the following: 1) I have carefully read the brochure and elect to enroll my dependent(s) as indicated on this form. 2) I meet the eligibility requirements for this coverage as described in the plan materials.

Signature of Student: _____ Date: _____

*Student being enrolled must sign form in order to be processed.*****A \$15 processing fee applies to all transactions******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**. Email or mail enrollment form along with premium payment to: Gallagher Student Health & Special Risk

Mail: P.O. Box 845663, Boston MA 02284-5663

Email: enrollmentteam@gallagherstudent.com**To be completed by Gallagher Student Health**

____ Approved _____ Denied Date: _____ Effective Date: _____ Initials: _____