

**Boston College 2009-2010 Policy Year
Student Injury and Sickness Insurance Plan Dependent Enrollment Form**

(Please Print)

Student Name _____
 _____ Last _____ First _____ Initial _____
 Home Address _____
 _____ Street _____ City _____ State _____ Zip Code _____
 Boston College ID # _____ Male _____ Female _____ Date of Birth ____/____/____
 _____ M _____ D _____ Y
 Phone Number _____ Email Address _____

DEPENDENT ENROLLMENT Please circle selected coverage.

Dates of Coverage	First Semester (8/7/2009 – 1/10/2010)	Second Semester (1/11/2010 – 8/6/2010)
Enrollment Deadline	September 18, 2009	January 25, 2010
Spouse	\$1,844.00	\$2,176.00
One Child	\$970.00	\$1,142.00
All Children	\$1,440.00	\$1,698.00

Please Note: Enrollment Forms will not be accepted after these deadlines.

List dependent(s) to be insured below. Dependent coverage is available only when the student is also insured under this plan and cannot exceed coverage purchased by the student. Dependents need to be enrolled by the deadlines listed above. In the event of a qualifying event (e.g., birth of child, marriage, etc.), the Dependent Enrollment form and payment must be received by Gallagher Koster within 31 days of the qualifying event. Dependent Enrollment forms will not be accepted after the deadlines.

	First Name	M. I.	Last Name	Date of Birth
Spouse				
Child				
Child				
Child				

Notice to Students:

Coverage will be effective the first date of the coverage period when the correct premium is received by Gallagher Koster by the enrollment deadline. Dependent Enrollment forms will not be accepted after the enrollment deadline has passed. It is the student's responsibility for timely renewal payment. 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 eligibility, the premium is not refundable.

Signature of Student: _____ Date: _____

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 Koster**. Mail enrollment form along with premium payment to:

**Gallagher Koster
P.O. Box 845663
Boston MA 02284-5663
1-800-394-4026**

Please include an additional \$5.00 Processing Fee with your enrollment form.

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.