2019-2020 Student Health Insurance Plan
Doctoral Candidate Enrollment Form

This form is used by doctoral candidates completing their defense within the first six weeks of the semester. 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.

(Please Print)
Student Name ______________________________________________________________________________________________________

Last/Family Name      First Name    Middle Initial

Home Address __________________________________________________________________________________________________

Street or P.O. Box     City     State             Zip Code

Eagle ID# _______________________________  Male       Female

Date of Birth _______/_______/_______  mm     /      dd      /    yyyy

Phone Number ____________________________ Email Address ___________________________________________

ENROLLMENT PERIOD (Please circle selected coverage)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Application Deadline</td>
<td>September 20, 2019</td>
<td>January 24, 2020</td>
<td>Premium Rate</td>
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<tr>
<td>Premium Rate</td>
<td></td>
<td></td>
<td>$1,300</td>
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<td></td>
<td></td>
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<td>$1,820</td>
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<tr>
<td>Processing Fee:</td>
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<td>+ $15.00</td>
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<tr>
<td>Total Payment Amount (Premium plus Processing Fee):</td>
<td></td>
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</tbody>
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Notice to Students: This Enrollment Form must be received with payment by Gallagher Student Health & Special Risk on or before the enrollment deadline. 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:
Credit Card: Charge to my (check one) ___ Visa     ___ Master Card
Card Number: ___________________________ Amount Charged: $_____________ Expiration Date: ____________
Name and Address of Cardholder _________________________________________________________________

Check or money order (International checks are not accepted): Make payable to Gallagher Student Health & Special Risk

Mail the enrollment form along with premium payment to:
Gallagher Student Health & Special Risk
P.O. Box 84566
Boston MA 02284-5663

Prepared by Gallagher Student Health & Special Risk
Revised May 2019