Gallagher | STUDENT HEALTH & SPECIAL RISK

Boston College 2019-2020 Student Health Insurance Plan
Petition to Add Coverage – Student ONLY Form

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

(Please Print)
Student Name _____
Last/Family Name First Name Middle Initial
Permanent U.S. Address _____
Street or P.O. Box City State Zip Code
Eagle ID # _____ Male ☐ Female ☐ Date of Birth _____/_____/_____
mm / dd / yyyy
Phone Number _____ Email Address _____

Student Status: ☐ **International** ☐ **Domestic**

Class Level: ☐ **Undergrad** ☐ **Graduate** ☐ **Law**

Name of Individual Completing Form _____
(If other than student)

Relationship to Student _____

Students can only add coverage if there is a qualifying event. A qualifying event is defined as:

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

Please detail your extenuating circumstances explaining the reason you wish to enroll yourself:
_____
_____
_____
_____

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 60 days of your last day of coverage. If this form is not received within 60 days of your last day of coverage, the effective date will be the date that this form is received.

I understand that this Petition is subject to the approval of Boston College and subject to the payment of any applicable premium. Premium is pro-rated using monthly rate. Once your petition has been processed, coverage cannot be cancelled, except for eligibility reasons.

_____ _____
Signature of Person Completing Form **Date**

Please complete form with payment and return it with a letter from your previous carrier confirming loss of coverage to Enrollmentteam@gallagherstudent.com or mail to Gallagher Student Health & Special Risk, P.O. Box 845663, Boston MA 02284-5663

PAYMENT INSTRUCTIONS:

Charge to my (check one): ___ Visa ___ Master Card
Card Number: _____+ $15 Processing Fee Amount Charged = $ _____
Expiration Date: _____
Print Name and Address of Cardholder_____

Check or money order (International checks are not accepted): Make payable to **Gallagher Student Health & Special Risk**
☐ **Enclosed is my check** $ _____+ $3 Processing Fee = $ _____

Prepared by Gallagher Student Health & Special Risk
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