



### Boston College 2020-2021 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 this form and return it with **a letter from your previous carrier confirming loss of coverage to:**  
[studentservices@bc.edu](mailto:studentservices@bc.edu)

<b>To be completed by Boston College:</b>		
<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date _____	Effective Date _____ Initials _____