BOSTON COLLEGE
Ever to Excel

2019-2020 Student Health Insurance Plan
2020 Summer Enrollment Form for Incoming Students

This form is used by incoming students in the programs listed below. You must be an incoming student enrolled in summer school classes at Boston College to be eligible.

(Please Print)
Student Name _____
Last/Family Name First Name Middle Initial

Home Address _____
Street or P.O. Box City State Zip Code

Boston College Eagle ID# _____ Male ☐ Female ☐ Date of Birth _____/_____/_____
mm / dd / yyyy

Phone Number _____ Email Address _____

ENROLLMENT PERIOD:

Summer 2020 **Coverage Period: 05/10/2020 – 08/06/2020**	
Application Deadline: June 15, 2020	
Premium Rate:	$780
Processing Fee:	+ $15
Total Payment Amount (Premium plus Processing Fee):	**$795**

Select the program you are enrolled in:

☐ Graduate School of Theology and Ministry
☐ Lynch Graduate School of Education
☐ Graduate School of Nursing
☐ Graduate School of Social Work
☐ Carroll Graduate School of Management
☐ Graduate School of Arts & Sciences
☐ Incoming Athletes

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:** _____

Email the enrollment form to: enrollmentteam@gallagherstudent.com

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