

# Petition to Add Frequently Asked Questions

Please read the information below carefully before completing a Petition to Add form.

## **If I lose coverage under another insurance policy, can I enroll in the school's plan?**

Yes, if you waived the Student Health Insurance Plan and then lose coverage under that plan due to a qualifying event (see specific question below) you may submit a Petition to Add form. Make sure you read the form carefully as it contains very specific information on the Petition to Add process, including required documentation to show proof of loss. We will need to confirm your plan eligibility with your school before processing your request. Petition to Add forms are processed within 5-7 business days after confirming plan eligibility with your school.

## **Am I eligible to Petition to Add?**

You need to meet the definition of your plan's eligibility statement which you can find in your school's FAQ or in the plan brochure. To access these documents, click the "My Benefits and Plan Information" located on the left-hand side of this homepage.

Students who enroll on a voluntary basis are not eligible to petition to add and will need to wait until the enrollment period for the next plan coverage period in order to purchase coverage.

## **What is considered a qualifying event?**

- Reaching the age limit of another health insurance plan ( **Example: Turning Age 26** )
- Loss of health insurance through a marriage or divorce
- Involuntary loss of coverage through my parents health insurance plan
- Involuntary loss of coverage through my employer

## **What other information do I need to submit with the Petition to Add form?**

You must include documentation from your insurance company (for example a letter on the company's letterhead or Confirmation of Coverage form) confirming your loss of coverage and indicating your last date of coverage. The following are supporting documentation requirements:

- Must have the student's full name
- Must have the last date of your coverage ( termination date)
- COBRA eligibility letters can only be accepted if the letter states the student's full name and termination date. **A COBRA letter is not an official termination letter. COBRA eligibility letters are sent to you prior to losing coverage.**

Also please note the following:

- Supporting documents need to be in pdf format; they cannot be in Word doc or email format for authenticity reasons.
- Screenshots will not be accepted.

## **Will I have a break in coverage?**

You will not have a break in coverage if the Petition to Add form and applicable documents are received within 30 days of your qualifying event. If the Petition to Add form and required documentation are not received within 30 days of your qualifying event, the effective date will be the date this form and applicable documentation are received at Gallagher Student Health.

## **Will the premium be pro-rated?**

Yes, the premium you pay will be pro-rated on a monthly basis determined by the date of your Qualifying Event.



# Vanderbilt University Student Insurance Graduate & International Dependent Petition to Add Form

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

Please print clearly to ensure accurate processing.

Date \_\_\_\_\_

Student's Name \_\_\_\_\_ Student ID Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Telephone # \_\_\_\_\_ Email \_\_\_\_\_

Dependent Name 1: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender  Male  Female      Dependent Type:  Spouse  Child

Dependent Name 2: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender  Male  Female      Dependent Type:  Spouse  Child

Dependent Name 3: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender  Male  Female      Dependent Type:  Spouse  Child

Name of Individual Completing Form \_\_\_\_\_  
(if other than student)

Relationship to Student \_\_\_\_\_

Dependent coverage can only be added if there is a qualifying event. A qualifying event is defined as:

- Reaching the age limit of another health insurance plan
- Adoption, Birth, Marriage or Divorce
- Involuntary loss of coverage from another health insurance plan

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that this Petition is subject to the approval of Gallagher Student Health & Special Risk and subject to the payment of any applicable premium. Once your petition has been processed, it cannot be cancelled, except for eligibility reasons.

If you are completing this petition as a result of your dependent losing coverage under your previous insurance carrier, for whatever reason, you must include a letter from the 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 31 days of the last day of coverage. Forms received more than 31 days after the qualifying even will not be processed.

Signature of Person Completing Form \_\_\_\_\_

Date \_\_\_\_\_

Please complete form and return it with a letter from your previous carrier confirming loss of coverage to:

Gallagher Student Health & Special Risk, 500 Victory Road, Quincy, MA 02171 or email

[enrollmentteam@gallagherstudent.com](mailto:enrollmentteam@gallagherstudent.com).

**To be completed by Gallagher Student Health & Special Risk**

\_\_\_\_ Approved/ \_\_\_\_ Denied Date \_\_\_\_\_ Effective Date \_\_\_\_\_ Initials \_\_\_\_\_



## Vanderbilt Student Health Insurance Plan 2018-2019 Policy Year Dependent Enrollment Form

(Please Print)

**Student Name** \_\_\_\_\_ **Commodore ID#** \_\_\_\_\_  
Last First Middle Initial

**Permanent US Address** \_\_\_\_\_  
Street/PO Box City State Zip Code

**Date of Birth** \_\_\_\_\_ **Gender** \_\_\_\_\_ **Undergraduate / Graduate / International** (Please Circle)  
mm/dd/yyyy M / F

**Phone Number** \_\_\_\_\_ **Email Address** \_\_\_\_\_

Undergraduate Dates of Coverage	Annual Policy 8/12/18 - 8/11/19	Spring Semester 1/1/19 - 8/11/19	May Mester 5/1/19 - 8/11/19	Summer Term 6/1/19 - 8/11/19	Coverage Period Premium Total
<b>Application Deadline</b>	September 12, 2018	February 1, 2019	June 1, 2019	July 1, 2019	
Spouse	\$2,476	\$1,512	\$699	\$488	
One Child	\$2,476	\$1,512	\$699	\$488	
Two or More Children	\$4,952	\$3,024	\$1,398	\$976	
Spouse & Two or More Children	\$7,428	\$4,536	\$2,097	\$1,464	
<b>Processing Fee</b>					+\$15.00
<b>Total Payment Amount (Premium plus Processing Fee)</b>					
Graduate/ International Dates of Coverage	Annual Policy 8/12/18 - 8/11/19	Spring Semester 1/1/19 - 8/11/19	May Mester 5/1/19 - 8/11/19	Summer Term 6/1/19 - 8/11/19	Coverage Period Premium Total
<b>Application Deadline</b>	September 12, 2018	February 1, 2019	June 1, 2019	July 1, 2019	
Spouse	\$3,142	\$1,919	\$887	\$620	
One Child	\$3,142	\$1,919	\$887	\$620	
Two or More Children	\$6,284	\$3,838	\$1,774	\$1,240	
Spouse & Two or More Children	\$9,426	\$5,757	\$2,661	\$1,860	
<b>Processing Fee</b>					+\$15.00
<b>Total Payment Amount (Premium plus Processing Fee)</b>					

**Dependent coverage is available only:**

- It is the Insured student's responsibility to enroll eligible Dependents each year. Dependents are not automatically re-enrolled. Students need to purchase coverage for their eligible dependent(s) at the same time of their initial plan enrollment and must purchase the same period of coverage in which they are enrolled.
- **Dependent coverage is available only** when the student is also insured under this plan and cannot exceed coverage purchased by the student. Enrollment forms must be submitted within the designated deadline for the requested coverage period. In the event of a qualifying event (i.e. birth of child, marriage, etc.), this Dependent Enrollment form and payment must be received by Gallagher Student Health & Special Risk within 31 days of the qualifying event. Except for newborn infants, there is no pro-ration of the premium. Once a dependent is enrolled, coverage cannot be terminated unless the student loses eligibility.

	Last Name	First Name	MI	Date of Birth	Gender
<b>Spouse/Domestic Partner</b>					
<b>Child</b>					
<b>Child</b>					
<b>Child</b>					

**Notice to Students:** Enrollment Forms will not be accepted after the Enrollment Deadline has passed unless submitted due to a qualifying event. It is the student's responsibility to re-enroll their eligible dependents. Gallagher Student Health & Special Risk is under no obligation to send a reminder notice to the student; the student is responsible for timely premium payment and dependent enrollment.

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) Enrolled Dependent meets the eligibility requirements for this coverage as described in the brochure. 4) If it is later determined that the Dependent is not eligible, the premium will be refunded. 5) A Dependent cannot be insured under this Plan if the Insured Student loses eligibility under the Student Injury & Sickness Insurance Plan. 6) Once dependent coverage is purchased, coverage is non-renewable within the same policy year. 7) Other than for eligibility reasons, 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: \_\_\_\_\_

Name and Address of Card holder \_\_\_\_\_

**Check or money order (International checks are not accepted)**

Make check or money order payable to **Gallagher Student Health & Special Risk**. Email, Mail or fax enrollment form along with premium payment to:

**Gallagher Student Health & Special Risk P.O. Box 845663, Boston MA 02284-5663**

**Email:** [enrollmentteam@gallagherstudent.com](mailto:enrollmentteam@gallagherstudent.com)