Gallagher | STUDENT HEALTH & SPECIAL RISK

Cornell University

Extension of Coverage

Student Health Plan (SHP) Enrollment Form

STUDENT INFORMATION

Student Name_____ Date of Birth____/____/____ Gender _____
first name, middle initial, last name *mm / dd / yyyy*

7-digit Cornell ID#_____ Cornell Net ID_____ Current Phone #_____-_____-_____

Class Level (check one): ❒ Undergraduate ❒ Professional ❒ Graduate

Reason for extension request (Extension is contingent on validation of change in student eligibility):

❒ Graduating	❒ Leave of Absence (SHP)	❒ Leave of Absence (SHP Plus)*	❒ Other:_____
❒ Fall (Coverage Feb 1 – Apr 30) ❒ Spring (Coverage Aug 1 – Oct 31) ❒ August (Coverage Sep 1 – Nov 30)	LOA date:_____ (LOA beginning April 1st through end of plan year) Coverage (Aug 1- Oct 31)	LOA date:_____ *this is only available to students that were enrolled in SHP Plus and are on LOA	Separation Date:_____ Coverage (3 months from last date of eligible SHP or SHP Plus coverage)

TERMS: One-time 3-month extension of coverage. Extension is non-renewable. Student must be enrolled in SHP or SHP Plus to be eligible. Dependents must be enrolled in SHP to be eligible.

ENROLLMENT DEADLINE: 60 days after change in student eligibility per Certificate of Coverage

CANCELLATION POLICY: Extension may be cancelled at any time. No premium refund will be issued for cancellation requests submitted after the first effective day of the extension.

COVERAGE SELECTION AND PREMIUM DUE

Indicate requested coverage

❒ Student only	$855	❒ Student + Child	$1,710	❒ Student (formerly SHP Plus- now on LOA)	Will be invoiced for amt
❒ Student + Spouse	$1,710	❒ Student + 2 or more children	$2,565		
❒ Student + Spouse + 1 Child	$2,565	❒ Student + Spouse + or more children	$3,420		

PAYMENT INSTRUCTIONS: **All extensions must have proof of payment to be processed.**
Please go to: https://shpdirectpay.securepayments.cardpointe.com/ to pay for your coverage extension.
A copy of your payment receipt should be submitted with this application.

❒ I acknowledge that I am responsible for paying the premium for the extension of coverage for myself (and my dependents if applicable) within 60 days of my eligibility change. My failure to pay the premium within 60 days of the start of my extension will result in termination of my extension of coverage for myself and my dependents, and I will be billed by the provider for any charges incurred after my eligibility change.

SIGNATURES

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Student signature_____ Date____/____/____

PLEASE COMPLETE AND SUBMIT THIS FORM AND YOUR PROOF OF PAYMENT RECEIPT TO GALLAGHER STUDENT HEALTH VIA EMAIL: Quincy.BSD.enrollmentteam@AJG.com