NEW YORK REQUEST TO TERMINATE DEPENDENT STUDENT HEALTH INSURANCE COVERAGE

This form must be completed entirely to assure proper processing

This form is for Dependent Insurance Termination ONLY

Policy: If you are currently enrolled in the Student Health Plan (SHP) sponsored by your institution located in the state of New York, you can request a termination of dependent coverage. Your institution requires you to have active and comparable health insurance coverage, however you can request to terminate your dependents coverage. Termination will take effect at the end of the month during which the student provides notice, unless a later date is requested. If a refund is applicable, refunds will be prorated monthly, and a cancellation fee of $110 per canceled policy.

- Cancellation/termination can occur at any time for dependent coverage after July 31st, if payment has already been made.
- A cancellation request can be submitted after April 30th, and the cancellation fee will still be charged, but no premium refund will be issued.
- Cancellation of the coverage extension will only result in a refund if the termination request is submitted prior to the start of the extension.
- Cornell fall graduate coverage and any associated dependent coverage will automatically end on December 31st, and a pro-rated premium refund will be issued

Procedure:

Complete the ‘Contact Information’ section of the form with the student's information.

Complete the ‘Dependent Information’ section of the form. Forms with missing or incomplete information will not be processed

If you are continuing as a student, please submit this form for your dependent’s termination of coverage to Quincy.BSD.enrollmentteam@ajg.com

Students will be notified via email the status of their request within 7-10 business days

Student Contact Information:

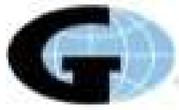
Name of School:____

Student Name:_____________________________ Student ID__________________

Address:____

Date of Birth:____/____/____Phone: (_____)___________Email:______________________

THE SECOND PAGE MUST BE COMPLETED



Dependent Information:

Dependent Name	Date of Birth	Relationship to Insured

Refund Acknowledgment:

______ By initialing here, I understand that I am completing an early termination for my dependent(s), I will only be receiving a partial refund of the student medical insurance premium.

By submitting this Request, I certify that:

1. I understand that if this request is approved, I cannot enroll my dependents in the school's student insurance plan until the next policy year
2. I certify that the above information is true and accurate

Please email the completed form and any attachments to Quincy.BSD.enrollmentteam@ajg.com

Signature:____Date:____/___/____