Gallagher | STUDENT HEALTH & SPECIAL RISK

Cornell University Student Health Plan (SHP)
Extension of Coverage Request Form

Student Name _____ Date of Birth _____ 7-digit Cornell ID# _____

Email _____ Phone _____

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

❒ Graduation • If going on leave prior to graduation, select Leave of Absence instead. • Extensions for May 2024 graduates not being processed at this time.	Graduation Term (Select one.) ❒ August 2023 ❒ December 2023
❒ Leave of Absence Effective Date of Leave _____	❒ Permanent Withdrawal Date of Separation _____

TERMS: One-time 3-month extension of coverage. Extension is non-renewable.

ENROLLMENT DEADLINE: 60 days following the later of the SHP coverage end date or first notification of the end date.

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.

Amount Due:

❒ Student only	$948	❒ Student and 1 Child	$1,896
❒ Student and Spouse	$1,896	❒ Student and 2 or More Children	$2,844
❒ Student, Spouse, and 1 Child	$2,844	❒ Student, Spouse, and 2 or More Children	$3,792

❒ 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 recission of my extension of coverage for myself and my dependents, and I will be billed by the provider for any charges incurred during the extension period.

❒ I acknowledge that by submitting this form by email, I am consenting to electronic communications. (If you prefer to receive communications by physical mail, see instructions below.)

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___/___/___

INSTRUCTIONS:

1. Before submitting this form, go to: https://shpdirectpay.securepayments.cardpointe.com/ to pay for your coverage extension. Coverage cannot be activated until payment is received.
2. A copy of your payment receipt (webpage or email) must be submitted with this application.
3. Submit this form and proof of payment to Gallagher Student Health to: Quincy.BSD.enrollmentteam@AJG.com. (If you prefer to receive communications by physical mail instead of electronically, mail this form with proof of payment to Student Health Benefits, 395 Pine Tree Rd., Suite 330, Ithaca NY 14850.)