Gallagher | STUDENT HEALTH & SPECIAL RISK

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 at any time. 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 will apply.

- 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 a coverage extension will only result in a refund if the termination request is submitted prior to the start of the extension.
- Coverage for Weill Cornell fall graduates will end on December 31, 2025. The dependent coverage will also end at this time and a pro-rated premium refund will be issued.
- Terminal PhD students and dependent coverage will end on the last day of the month in which their stipend terminates. Pro-rated premium refunds will be issued if applicable at that time.

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:_____

Gallagher | STUDENT HEALTH & SPECIAL RISK

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 Dependent 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:____/___/ ____