



Weill Cornell Medicine
Three-Month Continuation 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 Jenzabar ID: _____ CWID: _____ Current Phone # _____

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

- Graduation: please provide your program: _____ Leave of Absence Effective Date of Leave _____
Permanent withdrawal or Terminal Masters: Official exit date: _____

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

Check all boxes that apply

- Continue my enrollment in the Student Health Plan
Continue my dependent(s) in the Student Health Plan

PREMIUMS AND COVERAGE PERIOD

Table with 4 columns: Student, Quantity, Effective Date, Termination Date. Rows for Student and Dependendent(s).

PAYMENT INSTRUCTIONS: Continuation of Coverage will be billed to your student account through LEARN. Effective July 1, 2026, the monthly health insurance rate will be \$742.00. A monthly rate of \$729.00 will apply to any coverage request submitted before July 1, 2026. In addition to the monthly premium, a program fee of \$78.00 will be charged for each continued coverage request.

I understand that the office of Student Accounting will email my WCM email with the invoice. My failure to pay the premium within 60 days of the start of my continuation will result in termination of my continuation 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 TO GALLAGHER STUDENT HEALTH VIA EMAIL: Quincy.BSD.enrollmentteam@AJG.com; CC: Student-accounting@med.cornell.edu