Gallagher | STUDENT HEALTH & SPECIAL RISK

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

Reason for extension 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

❒ **Extend my enrollment in the Student Health Plan** ❒ **Extend my dependent(s) in the Student Health Plan**

PREMIUMS AND COVERAGE PERIOD

	Quantity	Effective Date	Termination Date
Student	1		
Dependendent(s)			

PAYMENT INSTRUCTIONS: Extensions will be billed to your student account through LEARN. You will be invoiced within 10 business. Please note that as of July 1, 2024, the monthly health insurance rate will be $729.00, plus a program fee of 78.00.

❒ 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 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 TO GALLAGHER STUDENT HEALTH VIA EMAIL: Quincy.BSD.enrollmentteam@AJG.com; CC: Student-accounting@med.cornell.edu