Gallagher | STUDENT HEALTH & SPECIAL RISK

University of South Florida Health Insurance Plan
2021-2022 Visiting Scholar Enrollment Form

Eligibility: All Visiting Scholars with a J-1 Visa and accompanying dependents with J-2 visa are eligible to enroll in the Mandated Health Insurance Plan.

(Please Print)

Name_____ Student ID_____
Last First Middle Initial

Local Address_____ Telephone #_____
Box Number/Street Address City State Zip Code

Male___ Female___ Date of Birth _____/_____/_____ Email Address_____
mm dd yyyy

Enrollment Period: Check the desired Period of Coverage

Check Here	Period of Coverage	Scholar	Spouse	One Child	2 or more Children	Spouse & 2 or more Children
	Annual (8/17/21-8/16/22)	$3,358	$3,358	$3,358	$6,716	$10,074
	Monthly	$280	$280	$280	$560	$840
	Weekly	$65	$65	$65	$130	$195

Calculating Your Payment.

Check here if your department will be paying for your coverage_____ Name of Department_____

Requested Effective Date of Coverage _____ **Requested Period of Coverage**: _____
mm/dd/yyyy mm/dd/yyyy

If electing to pay monthly/weekly: $_____ **X**_____ + **$15** = _____
Payment # of Months Processing Fee **Total Payment Enclosed**

Dependent coverage is available only: A) when the scholar is also insured under this plan. Scholars need to purchase coverage for their eligible dependent(s) at the same time of their initial plan enrollment and must purchase the same period of coverage as the scholar's period of coverage and cannot exceed coverage purchased by the scholar. For example, a scholar enrolled for annual coverage cannot purchase dependent coverage for the spring semester unless a qualifying event, as defined below, occurs A) When the Dependent Enrollment Form is received by the deadline stated on this form above. B) Scholars can add eligible dependent(s) if they experience one of the following qualifying events: (a) marriage (b) birth of a child, (c) divorce or (d) if the dependent is entering the country for the first time. If dependent enrollment meets one of these qualifying events, this Dependent Enrollment form, supporting documentation and payment must be received by Gallagher Student Health within 31 days of the qualifying event. If not received within 31 days of the qualifying event, the effective date of coverage will be the date this form and payment are received at Gallagher Student Health. Once a dependent is enrolled, coverage cannot be terminated unless the Scholar loses eligibility.

	First Name	MI	Last Name	Date of Birth
Spouse				
Child				
Child				

Notice to Students:
Coverage will be effective the effective date of the coverage period. It is the student's responsibility for timely renewal payment. By signing below, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form. 2) Rates are not prorated other than as listed on this enrollment form. 3) He/She meets the eligibility requirements for this coverage as described in the brochure and noted above. 4) If it is later determined that the student is not eligible, the premium will be refunded. 5) Other than for eligibility reasons, the **premium is not refundable**.

Signature of Student: _____Date: _____

You must be eligible to enroll in the Plan and meet the enrollment deadline in order for your enrollment to be accepted by us. If it is discovered that you do not meet the requirements, your premium will be refunded.

Please submit this enrollment form to Gallagher Student Health at enrollmentteam@gallagherstudent.com.
Once the form is processed, you will be notified and a payment link will be sent to you to complete the financial transaction.