Gallagher | STUDENT HEALTH & SPECIAL RISK

2020-2021 University of the Pacific Student Health Insurance Continuation Plan Enrollment Form for Dental Students

Eligibility: Only students who graduate, withdraw, or drop out AFTER the first 45 days from the start of the term, can purchase continuation coverage.

(Please Print)

Student Name_____ _____ _____
Last First Initial

Home Address_____ _____ _____ _____
Street City State Zip Code

Student ID #_____ Male_____ Female_____ Date of Birth _____/_____/_____
MM DD YYYY

Phone Number_____ Email Address _____

Student Category: Dental Student

STUDENT ENROLLMENT Please circle selected coverage.

Dates of Coverage	3 Months Fall 1/1/21-3/31/21	6 Months Fall 1/1/21-6/30/21	3 Months Spring 7/1/21-9/30/21	6 Months Spring 7/1/21-12/31/21	Premium Payment
Dental Student Only	$844.67	$1,689.34	$844.67	$1,689.34	
	Processing Fee				$15.00
	Total Payment				

Please Note: Enrollment Forms will not be accepted after these deadlines

Notice to Students:
Coverage will be effective the first date of the Coverage Period when the correct premium is received by Gallagher Student Health & Special Risk by the Enrollment Deadline; Enrollment Forms will not be accepted after the Enrollment Deadline has passed. 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) Enrolled Student meets the eligibility requirements for this coverage as described in the brochure. 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: _____

PAYMENT INSTRUCTIONS:

Charge to my (check one): ___ Visa ___ Master Card

Card Number: _____ Amount Charged: $_____ Expiration Date: _____

Print Name and Address of Card holder_____ _____

Check or money order (International checks are not accepted)

Make check or money order payable to **Gallagher Student Health & Special Risk**. Mail enrollment form along with premium payment to:

Gallagher Student Health & Special Risk
P.O. Box 845663
Boston MA 02284-5663

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.