Gallagher | STUDENT HEALTH & SPECIAL RISK

Florida International University Student Health Insurance Plan

2018-2019 Visiting Scholar Enrollment Form

(Please Print)

Scholar Name_____ _____ _____ Date of Birth _____
Last First Initial MM/DD/YYYY

US Address_____ _____ _____ _____
Street City State Zip Code

Phone # _____ Email Address _____

Gender: Male ____ Female _____ Panther ID #_____ FIU Dept: _____

Immigration Status:J-1 ____ Other _____ If other, please specify_____

DEPENDENT INFORMATION

Dependent coverage is available only when the Scholar is also insured under this plan and cannot exceed coverage purchased by the Scholar. Dependents must be enrolled at the same time as the Scholar. In the event of a qualifying event (i.e. birth of child, marriage, etc.), Dependent Enrollment form and payment must be received by Gallagher Student Health & Special Risk within 31 days of the qualifying event. There is no pro-ration of the premium. Once a dependent is enrolled, coverage cannot be terminated unless the Scholar loses eligibility.

List Dependent(s) to be insured below:

	First Name	M. I.	Last Name	Gender	Date of Birth
Spouse					
Child					
Child					
Child					

Requested effective date of coverage _____ for _____ months (must round up number of months).
MM/DD/YYYY # of months

PAYMENT CALCULATION

	Monthly Premium	Number of Months	Total Premium
Scholar	$197.42	X	
Spouse	$197.42	X	
One Child	$197.42	X	
Two or More Children	$394.84	X	
Spouse & Two or More Children	$592.26	X	
Processing Fee ($15 if paying by credit card)			
Total Payment Due			

Notice to Scholars: Coverage will be effective the first date of the Coverage Period when the correct premium is received by Gallagher Student Health & Special Risk. It is the Scholar's responsibility for timely renewal payment. By signing below, the scholar 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 Scholar meets the eligibility requirements for this coverage as described in the brochure. 4) If it is later determined the Scholar is not eligible, the premium will be refunded. 5) Other than for eligibility reason, the premium is not refundable.

Signature of Scholar: _____ Date: _____

PAYMENT METHOD: Department _____ Credit Card _____
Charge to my (check one): ___ Visa ___ Master Card

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

Print Name and Address of Card holder_____ _____