Gallagher | STUDENT HEALTH & SPECIAL RISK

Smith College
Blue Cross Blue Shield of Massachusetts
2019-2020 Continuation Plan Enrollment Form
Deadline: August 31, 2020

Student's Last Name _____ First Name _____ Initial _____ Student ID # _____

Street Address _____ City _____ State _____ Zip Code _____ (_____) _____ Telephone Number

Email _____ Gender (male/female) _____ Date of Birth (mm/dd/yyyy) _____

Eligibility Requirement: Eligibility is limited to students who have a) been continuously insured under the school's Blue Cross Blue Shield of Massachusetts Student Health Insurance Plan (SHIP) for the 2019-2020 Policy year with coverage terminating in August 2020 and b) are not eligible for the schools SHIP for 2020-2021. Additionally, students are not eligible if they are an international student returning to their home country or if they are a student who had been enrolled in their school's SHIP as part of the Mass Health Premium Assistance (MHPA) program. No dependent coverage is available. Your eligibility will be verified with your school.

Eligible students may elect to enroll for one additional semester of coverage as outlined in the table below. Please note that the term of coverage cannot be reduced or extended beyond the dates below. Coverage under the Continuation provision is subject to the rates and benefits selected by the school for 2020-2021. For more information on plan design, visit your school's page at http://www.gallagherstudent.com/.

Calculate Your Premium

Coverage is only available for the term described below. You cannot re-enroll in the Continuation Plan after your Period of Coverage has expired. Enrollment in this Continuation Plan must be made within **15 days** from the date that coverage terminates under the student's active Student Injury and Sickness Insurance Plan. 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 you do not meet the requirements your premium will be refunded. Add the amounts in the Total Premium Column to confirm total payment.

	Premium	Effective Date	Termination Date	Total Premium
Student Only	$1,059	August 15, 2020	January 14, 2021	$1,059
			Processing Fee	$15.00
			Total Payment Enclosed	

Notice to student: By signing below, the student acknowledges the following: 1) Student elects to continue coverage for the coverage period as indicated above; 2) Student has reviewed the eligibility requirements and attests that they are eligible for the Continuation Plan, 3) Continuation coverage can only be purchased for the time period indicated and is non-renewable; and 4) If it is later determined that the eligibility or enrollment requirements have not been met, coverage will be terminated and the premium will be refunded.

Signature of Student:_____ **Date:**_____

PAYMENT INSTRUCTIONS:
Charge to my (check one): ___Visa ___Master Card

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

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 or email the enrollment form along with premium payment to: Enrollmentteam@gallagherstudent.com or **Gallagher Student Health & Special Risk, P.O. Box 845663, Boston MA 02284-5663**