WELLFLEET

Student Health Insurance Qualified Late Enrollment Form

This form must be completed by students who have a qualifying life event and are (1) registered for classes, (2) subject to the requirement for health insurance coverage and (3) meet the eligibility requirements set forth in the benefits policy.

STUDENT INFORMATION: (*ALL* fields are required)

School Name: _____

Student Name: (Last) _____ (First) _____ (MI) _____ Date of Birth: ____/____/____

Student ID#: _____ Gender: ___ Email Address: _____ Social Security Number #: ____-____-____

Mailing Address: (Street Address) _____ Telephone #: _____ -_____ -_____

City _____ State _____ Zip Code _____ Effective Dates Requested: _____

Class: (Undergrad) _____ (Graduate) _____ Citizenship: (Domestic) _____ (International) _____

DEPENDENT INFORMATION: (*if applicable*)

			Date of Birth (mm/dd/yyyy)	Gender	SSN#
Spouse's Name: (Last) _____	(First) _____	(MI) ___	__/__/____	_____	_____
Child's Name: (Last) _____	(First) _____	(MI) ___	__/__/____	_____	_____
Child's Name: (Last) _____	(First) _____	(MI) ___	__/__/____	_____	_____

Effective Dates of Coverage: _____

Qualifying Event Information and Required Documentation

Identify the qualifying event for you and/or your eligible dependents. You must submit the appropriate required documentation, proof of prior coverage, and this completed form. Application for enrollment must be submitted within 31 days from which the qualifying event occurred unless otherwise stated in the Master Policy. Improper documentation will result in delay of coverage.

	Qualifying Event	Documentation Required
Please check the box that is applicable to your situation. A box MUST be checked and the appropriate documentation MUST accompany this form.		
[ ]	Involuntary loss of coverage (does not include loss due to failure to pay premiums or termination of coverage for cause) Reason for loss of coverage: _____	Written documentation from the insurance company, on company letterhead, providing the names of the covered participants, date coverage ends and reason for loss of coverage
[ ]	Involuntary loss of coverage due to turning age 26	Written documentation from the insurance company, on company letterhead, providing the names of the covered participants, date coverage ends and reason for loss of coverage
[ ]	Student arriving from another country	Copy of visa documentation for student arriving from another country
[ ]	New dependent – spouse	Copy of marriage certificate
[ ]	New dependent – newborn	Copy of birth certificate/birth record
[ ]	New dependent – adopted child	Copy of adoption paperwork for adopted child
[ ]	New dependent – spouse or child(ren) arriving from another country	Copy of visa documentation for spouse or child(ren) arriving from another country

I certify that the information given by me to all questions on this enrollment form are, to the best of my knowledge and belief, true and correct and that I have not knowingly withheld any pertinent facts or circumstances.

Student's signature _____ Date _____

Parent's signature _____ Date _____

(Parent(s) must sign for students who are under age 18.)

Please complete this form and submit along with a copy of the required documentation. Upon review you will be advised of the status of your request, premium amount, and payment options.

Please send completed form and required documentation to:

Email: webenroll@wellfleetinsurance.com

or

Mail: Wellfleet Group LLC
Attention: QLE Enrollment
2077 Roosevelt Avenue, Springfield, MA 01104