National Guardian Life Insurance Company

Bryant University
2016-2017 Qualifying Event Enrollment Form

Student Name _____ _____ _____
Last Name First Name MI

Student ID _____ Date of Birth ___ / ___ / ___ Gender _____

Email Address _____ Telephone #____ - ____ - _____

Mailing Address _____
House/Building Number and Street Name

_____ _____ _____ _____
Apt or Box # City State Zip Code

Please detail your extenuating circumstances explaining the reason you wish to enroll yourself.

_____
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If you are completing this petition as a result of losing coverage under your previous insurance carrier, you must include a letter from your previous carrier confirming loss of coverage and indicating the last date of coverage. In order not to have a lapse in coverage, this petition must be received within 31 days of your last day of coverage. If this form is not received within 31 days of your last day of coverage, the effective date will be the date that this form is received at **University Health Plans**.

Payment Instructions: The premium amount will be billed to your Student Account.

Delivery Instructions: You may fax, e-mail or mail a copy of this enrollment form to 1-617-472-6419 (f), moneill@univhealthplans.com, or University Health Plans, One Batterymarch Park, Quincy, MA 02169

I understand that this enrollment form is subject to the approval of Bryant University. I also understand that if approved, the applicable premium will be billed to my Student Account.

Student's Signature_____ Date _____

If approved, your insurance ID card will be sent to the Bryant University Health Center.