

**Student Health Insurance
Petition to Enroll Form after Published Deadline**

This form must be completed in its entirety in order to be reviewed.

Student's name _____ I.D. number _____
(Please Print)

Address _____

Date of birth _____ Telephone # _____ Email _____

Individual completing form _____ Relationship to student _____

Semester requesting coverage _____ Premium amount _____

Please provide in detail your extenuating circumstances explaining the reason for your request to enroll yourself after the enrollment deadline.

I understand that this Petition is subject to departmental approval and to the payment of any applicable premium. I understand that any decision made is final.

Signature _____ Date _____

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 insurance carrier confirming loss of coverage, reason for loss of coverage, and indicating the last date of coverage. In order to avoid a lapse in coverage, this petition must be received within 31 days of your last day of coverage. If this form is received within those 31 days, the effective date will be the date that this form is received by Student Health Insurance.

Please complete and return to: studins@ucmail.uc.edu or University of Cincinnati, Student Health Insurance Office, P.O. Box 210010, Cincinnati, Ohio 45221-0010 or Fax to (513) 556-6655

For departmental use only.

Approved _____ Denied _____ Effective Date _____