



Change of Name Form

This form needs to be completed in order to request a change to your name or a dependent's name. This form must be submitted with proof of your name change, i.e.: marriage license, divorce papers, or court documents relating to legal change of birth name.

Check the appropriate box: I am an Insured student I am the dependent of an Insured student

Provide your name as it is currently listed on your student health insurance ID card:

Current Name _____
Last First Middle Initial

Name of School or Program: _____

Insurance ID#: _____ Date of Birth ____/____/____
MM / DD / YYYY

Provide your Requested Name Change:

New Name _____
Last First Middle Initial

Provide Phone Number or Email address in the event we need to contact you:

Phone Number _____ Email Address _____

By signing below, you certify that all information you provided is correct to the best of your knowledge.

Signature: _____ Date ____/____/____

Please submit completed form with backup documentation to:

Fax: 617-479-0860

Mail: Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171

Email: enrollmentteam@gallagherstudent.com

Please allow 7-10 business days from date of receipt for processing.