

2009-2010 Health Insurance Waiver Form for Tufts University's Boston & Grafton Campuses

Massachusetts General Law and University Policy mandate health insurance coverage for all matriculated students. In order to waive participation in Tufts University's student health insurance plan, a Waiver Form must be completed annually, by August 31st, to certify participation in an alternate health plan. Students are automatically billed for the health insurance each year. Completion of the Waiver Form is necessary to receive credit to your student account for the health insurance fee. Incomplete or unsigned forms will not be accepted.

Indicate School: Dental Medical Nutrition Public Health Programs Veterinary

Last Name _____ **First Name** _____

Tufts ID/SSN _____ **Birth Date** _____

Address _____

Number & Street

City

State

Zip Code

State Law 114.6 CMR 3:00 Section 3.05 Waiver Participation

Coverage must include: preventive and primary care, emergency services, surgical services, hospitalization benefits, ambulatory patient services and mental health services. The services covered must be accessible in the area where the school is located.

Students may not waive based on the following plans:

1. Plans from insurance carriers outside the U.S. and coverage by foreign National Health Service programs, including Canadian insurance plans.
2. Plans that provide coverage through a closed network of providers, not reasonably accessible in the area where the student attends school, for all but emergency services. (Out-of-area HMO's)
3. Payment from the Massachusetts Uncompensated Care Pool.

Insurance Company's Name _____

Policy Number _____ **Insurance Company's State** _____

Policyholder's Name _____ **Relationship to Student** _____

I certify that I am covered by the insurance policy listed above for the academic year beginning on September 1, 2009 (or, on the date I cancel my THP coverage) and ending August 31, 2010. I also certify that this policy is comparable to the minimum coverage required by the Commonwealth of Massachusetts. I understand that by completing this Waiver, I am responsible for my medical expenses, and neither Tufts University, nor the University's health insurance carrier will be responsible for those expenses.

Signature: _____ **Date:** _____

If currently enrolled in Tufts Health Plan, cancel my coverage on: ____/____/____. **Indicate coverage level:**
___ Individual; ___ Two-Person; ___ Family Plan. A prorated credit will be posted to your student account, by the Bursar.

Signature: _____ **Date:** _____

Return to: Student Advisory & Health Administration Office, Posner Hall, 200 Harrison Avenue, Boston, MA 02111

Fax: 617-636-2708

Phone: 617-636-2712 or 617-636-2701

For Office Use Only:

Credit 2010 FL: \$ _____ (09/01/09 - 02/28/10)

If canceling coverage, Cancellation date: ____/____/____

Credit 2010 SP: \$ _____ (03/01/10 - 08/31/10)

Tufts Health Plan notified on: ____/____/____

Total Credit: \$ _____

Bursar Notified: ____/____/____ Sheet no.: _____ or e-mail _____

Processed by: _____