2008-2009 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 qualifying 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 ____Veterinary ____MS Program (HC, MPH, PREP)

Last Name_____ First Name _____

Tufts ID/SSN_____ Birth Date _____

Address_____
Number & Street City State Zip Code

State Law Requirements: *Regulation 114.6 CMR 3:00, Section 3.05 can be found at http://www.tufts.edu/saha/images/Regs06.pdf*

A copy of the student's insurance card, or policy, must be attached to the Waiver Form.
The Waiver will not be accepted without this documentation.

Coverage must include: preventive and primary care, emergency services, surgical services, hospitalization benefits, ambulatory patient services and mental health services.

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 Name _____

Policy Number_____ Company's City & 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, 2008, or on the date I cancel my THP coverage, and ending August 31, 2009. 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, not the University's health insurance carrier will be responsible for those expenses.

Signature: _____ **Date:** _____

If you are currently enrolled in *Tufts Health Plan* and are now cancelling:

Cancel on: _____/_____/____ Type of Coverage: ____Individual ____2 Person ____Family Plan

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 / 2701

For Office Use Only:

Credit 09 Fall: $ _ _ _ _ _ _ _ _ (09/01/08 - 02/28/09)

Credit 09 Spr: $ _ _ _ _ _ _ _ _ (03/01/09 - 08/31/09)

Total Credit: $ _____

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

If canceling coverage, *THP* notified: _____ / _____ / _____ Processed by: _____

10/08