2009-2010 Health Insurance Waiver Form *for* Tufts University's Sackler School Students

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.

Indicate Program: _____PhD _____Clinical Research _____Visiting Student

Last Name_____ **First Name** _____

Tufts ID/SSN_____ **Birth Date** _____

Address_____
Number & Street City State Zip Code

State Law Regulation 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.

□ Attach Payroll Deduction Form

Insurance Company 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* and are now canceling: □ Attach Stop Payroll Deduction Form

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 or 617-636-2701

For Office Use Only:

Copy of Waiver sent to Sackler School on: _____ / _____ / _____

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

Tufts Health Plan notified on: _____ / _____ / _____

Copy of Transmittal Form sent to Sackler School on: _____/_____/_____

Processed by: _____

Revised 06/09