



Student Advisory & Health Administration Office
 200 Harrison Avenue, Boston, MA 02111
 phone: 617-636-2701 fax: 617-636-2708

Withdrawal or Dismissal - Tufts Health Plan Cancellation Form

1. Name: _____
2. Social Security No.: _____
3. School: _____ Program: _____ Class: _____
4. Mailing Address: _____
 _____ Phone: _____
5. **Date of Withdrawal or Dismissal:** _____

The Policy: Students withdrawn or dismissed from Tufts University's Dental, Medical, Nutrition, Sackler, or Veterinary Schools have the option of continuing enrollment in the student health insurance plan for up to sixty (60) days following their withdrawal or dismissal date from Tufts University. The student has fifteen (15) calendar days from his/her withdrawal or dismissal date to notify the Student Advisory & Health Administration Office of his/her intent to continue enrollment and to verify that full payment of the health insurance cost has been made. The Verification of Payment Form is available at the Student Advisory & Health Administration Office. Failure to notify the Student Advisory & Health Administration Office and to complete the Verification of Payment Form within the fifteen (15) day period will result in the student's health insurance policy being cancelled on the date of withdrawal or dismissal from Tufts University.

Insurance Information:

6. **Type of Coverage:** _____ Individual _____ Two-Person _____ Family
7. **In accordance with the above stated policy, please cancel my TUFTS Health Plan health insurance coverage, effective** ____/____/____ .
8. _____
Student's Signature **Date**

For Office Use Only:

Cancellation Date: ____/____/____ Credit Amount \$ _____
 Bursar Notified: ____/____/____
 THP Notified on: ____/____/____