



Affiliate Cancellation Application AY2023-2024

This application will be processed in accordance with the [HUSHP Affiliate Cancellation Policy](#). All cancellation rules apply.

COMPLETE YOUR INFORMATION

Affiliate's Last Name

Affiliate's First Name

HUID Number

Email Address

CANCELLATION IS FOR (select one)

- Fall term (August 1 through January 31)
- Spring term (February 1 through July 31)
- Both terms (August 1 through July 31)
- Due to a qualifying event (*documentation is required within 45 days of event*)

Check one:

- Gaining eligibility
- Divorce

CANCELLATION IS FOR THE FOLLOWING MEMBER(S) (select one)

- I am requesting to cancel coverage for myself and all my dependents
- I am requesting to cancel coverage ONLY for the dependent(s) specified below:

LIST YOUR DEPENDENTS

Dependent #1 Last Name

Dependent #1 First Name

Dependent #1 Date of Birth

Dependent #2 Last Name

Dependent #2 First Name

Dependent #2 Date of Birth

Dependent #3 Last Name

Dependent #3 First Name

Dependent #3 Date of Birth

Dependent #4 Last Name

Dependent #4 First Name

Dependent #4 Date of Birth

SIGNATURE AND DATE

By submitting this application, you acknowledge that you have read and understood the affiliate cancellation policy and that re-enrollment into the plan will not be available until the next open enrollment period or within 45 days of your dependent(s) losing other health insurance coverage (documentation required).

Signature

Date signed

Return by email to HUSHP Member Services at mservices@huhs.harvard.edu

For additional information, please review the [Affiliate Cancellation Policy and Application webpage](#)