HARVARD UNIVERSITY
Student Health Program

MASSACHUSETTS

Affiliate Enrollment Application AY2023-2024

Attention Administrators: If paying for the affiliate's insurance, email this application to BOTH Accounts Payable and HUSHP Member Services.

STEP ONE: COMPLETE YOUR INFORMATION

Affiliate's Last Name_____

Affiliate's First Name _____

HUID Number_____

Email Address_____

STEP TWO: YOUR ELIGIBILITY (select one)

☐ I am enrolling as part of Open Enrollment between July 1- August 31 (fall term); December 1- February 29 (spring term)

☐ I am enrolling due to a life-changing event *(contact HUSHP to confirm rates)*

☐New appointment

☐Loss of insurance

☐Marriage/birth of a child

☐Entry into the United States

Proof of your event is required and must be included with this application within 45 days of the life-changing event. Enrollments due to a life-changing event will be prorated based on the first day of the month in which the event occurs.

STEP THREE: SELECT ENROLLMENT TERM *(payment is required in full for the term that you are enrolling for)*

☐Full year (12 months); August 1, 2023-July 31, 2024

☐ Fall term (6 months); August 1, 2023-January 31, 2024

☐ Spring term (6 months); February 1, 2024-July 31, 2024

STEP FOUR: SELECT TYPE OF CONTRACT

Affiliate

☐6 months; $6,757.50

☐12 months; $13,515.00

Affiliate + 1

☐6 months; $15,219.00

☐12 months; $30,438.00

Affiliate + 2 or more

☐6 months; $21,983.00

☐12 months; $43,966.00

Dependent #1 only *(excludes affiliate)*

☐6 months; $8,461.50

☐12 months; $16,923.00

Dependent #2 only *(excludes affiliate)*

☐6 months; $6,764.00

☐12 months; $13,528.00

STEP FIVE: ADD DEPENDENTS *(BCBSMA now accepts a third gender. We recognize that not all members identify as Male, Female, or Non-Binary. However, these values are currently the only HIPPA-compliant values for gender.)*
List all eligible dependents you want to be covered under your medical policy:

Married Spouse

Married Spouse Last Name _____

Married Spouse First Name _____

Married Spouse Date of Birth _____

Married Spouse Gender:

☐Male

☐Female

☐Non-Binary

Children (through age 26 only)

Child #1 Last Name _____

Child #1 First Name _____

Child #1 Date of Birth _____

Child #1 Gender:

☐Male

☐Female

☐Non-Binary

Child #2 Last Name _____

Child #2 First Name _____

Child #2 Date of Birth _____

Child #2 Gender:

☐Male

☐Female

☐Non-Binary

Child #3 Last Name _____

Child #3 First Name _____

Child #3 Date of Birth _____

Child #3 Gender:

☐Male

☐Female

☐Non-Binary

Child #4 Last Name _____

Child #4 First Name _____

Child #4 Date of Birth _____

Child #4 Gender:

☐Male

☐Female

☐Non-Binary

STEP SIX: COMPLETE THE POST-DOC AFFILIATE ATTESTATION FOR ENROLLMENT IN HUSHP FORM

To enroll in Harvard University Student Health Program (HUSHP) coverage, the post-doc affiliate must satisfy both criteria listed below. HUSHP requires that both the individual requesting coverage and a department administrator confirm these facts by signing this attestation form.

1. Meets the definition of a postdoctoral appointment as defined by the Association of American Universities Committee on Post-Doctoral Education

- The appointee was recently awarded (for example, within the last 3 years) a Ph.D. or equivalent doctorate (e.g., Sc.D., M.D.) in an appropriate field; and
- The appointment is temporary; and
- The appointment involves substantially full-time research or scholarship; and
- The appointment is viewed as preparatory for a full-time academic and/or research career; and
- The appointment is not part of a clinical training program; and

- The appointee works under the supervision of a senior scholar or a department in a university or similar research institution (e.g., national laboratory, NIH, etc.); and
- The appointee has the freedom and is expected to publish the results of their research or scholarship during the period of the appointment.

2. Meets the HUSHP Affiliate Eligibility Policy
    - The postdoc must have a current Harvard appointment and not be eligible for employer-sponsored health insurance.

By signing below, I attest to the fact that the post-doc affiliate requesting enrollment in HUSHP meets the criteria listed above. This statement is true and accurate to the best of my knowledge.

Signature of post-doctoral affiliate
Printed name of post-doctoral affiliate_____
Date signed_____

Signature of department administrator
Printed name of department administrator_____
Date signed_____
Email of department administrator_____

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

For additional information, please review the Enrollment Policy and Application for Post-Doctoral Affiliate webpage.