Policy Title: HUSHP LOA Cancellation Policy
Issuer: Harvard University Student Health Program **Plan Year:** AY2023-2024
Revised Date: N/A

HARVARD UNIVERSITY
Student Health Program

HUSHP Leave of Absence Cancellation Policy and Application

POLICY STATEMENT
This policy applies to any student who enrolled in the 6-month extension of coverage during their leave of absence (LOA). You may be eligible to cancel if you meet the following criteria:

- You are currently enrolled in the LOA coverage and have completed 3 months of coverage.
- The cancellation application must be received **10 business days before the 1st day of the 4th month of coverage.**
  - *Example: If enrolled for the period 8/1-1/31, cancellation must be received on or before 10/19.*
- **This cancellation request will result in a loss of coverage for myself and any dependents I have enrolled on the leave of absence plan. Re-enrollment into the plan will not be available.**

☑ If approved:

- Coverage will be cancelled on the last day of the 3rd month of coverage
- Both parts of the insurance, the Student Health Fee and the Student Health Insurance Plan will be cancelled
- An applicable credit will be issued via the same method of payment (to your student bill or via check or credit card) within 10-20 business days.
- Appeals to this policy will not be considered.

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HARVARD UNIVERSITY
Student Health Program

HUSHP Leave of Absence Cancellation Request Form AY2023-2024

This application is to request a partial cancellation at the three-month mark of my LOA coverage extension. It does not cancel the first three-months of my leave of absence coverage.

Return by email to: HUSHP Member Services ▪ Email mservices@huhs.harvard.edu ▪ Office: (617) 495-2008

Last Name	**First Name**
HUID	**Email**

This application will be processed as follows:

If received by the last day of the third month of leave of absence coverage:

- The second half of my leave of absence coverage will be cancelled, and a credit will be issued to me via the same method of payment.
- Any medical and prescription services received on and after the 1st day of the 4th month will not be covered by the plan and I will be responsible for all costs incurred after the plan termination date.

If received beyond the last day of the third month of coverage:

- The second series of 3 month leave of absence coverage will **NOT** be cancelled
- A credit will not be issued, you will be covered for the remaining 3 months

Cancellation is for:

☐ The three (3) remaining months of non-used LOA coverage
Non-used coverage period: _____

☐ **I understand that this cancellation request will result in a loss of coverage for myself and any dependents I have enrolled on the leave of absence coverage extension. Re-enrollment into the plan will not be available.**

Signature	Date