HARVARD UNIVERSITY
Student Health Program

Student Dependent Cancellation Application AY2023-2024

This application is to cancel coverage for student dependents. It does NOT cancel the student's medical coverage.

COMPLETE YOUR INFORMATION

Student's Last Name

Student'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 needed to cancel/prorate coverage; please submit with this application)*

Check one:

☐Gained other medical coverage

☐Divorce

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

☐ I am requesting to cancel medical coverage for **ALL** my dependent(s)

☐ I am requesting to cancel medical 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, I acknowledge that I have read the dependent cancellation policy. I understand that my dependents' re-enrollment into the plan will not be available until the next open enrollment period or within 45 days of my dependent(s) losing their other health insurance coverage. Documentation of the life-changing event will be required to re-enroll.

Signature

Date signed

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

For additional information, please review the Student Dependent Cancellation Policy and Application webpage