HARVARD UNIVERSITY
Student Health Program

Optional AY23-24 Dental Plan Application for Harvard Extension School Students

Attention: Harvard Extension Students, use this application ONLY if:

- You are enrolling because of a loss of other (non-Harvard) dental insurance.
- You are adding dependents with a life-changing event.
- You are adding dependents to the dental plan who will NOT be enrolled in the Student Health Insurance Plan (medical plan).

Rates for the Academic Year: August 1, 2023-July 31, 2024

Contract Preventive Plan
Student only: $296
Student +1 dependent: $571
Student +2 or more dependents: $881

Contract Comprehensive Plan
Student only: $538
Student +1 dependent: $1,038
Student +2 or more dependents: $1,602

Step One: Complete Your Information

HUID Number _____

Student's Last Name _____

Student's First Name _____

Step Two: Select a Type of Contract

- I am a new student enrolling during the open enrollment, or I am enrolling myself/dependents due to a life-changing event.
- Rate will be prorated based on the life-changing event date.
- Official documentation of the event is required and must be submitted with this application.

Type of Contract:

☐ Preventive Plan

☐ Comprehensive Plan

☐ Individual (Student Only)

☐ Two-Person (Student + One Dependent)

☐ Family (Student + Two or More Dependents

Step Three: 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 HIPAA-compliant values for gender.

List all eligible dependents you want to be covered under your dental plan.

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)

Review Pediatric Essential Benefits prior to enrolling children under 19 years of age.

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 Four: Accept Terms, Sign, and Date the Application

I have read the dental policy on the webpage and reviewed the two plan options. **This is a contract that runs from 8/1 through 7/31.** The effective date may differ for enrollments due to a life-changing event.

I understand:

This is an optional plan that needs to be renewed. If I fail to renew my application for the next academic year by the deadline, I will not be able to enroll in this plan without a loss of other non-Harvard dental insurance.

Once I submit this application:

- This plan can only be canceled for a refund if my request is received by the enrollment deadline of 9/30 in which I or my dependents are enrolling, or within five days of submitting the enrollment application, or within 45 days of gaining other dental coverage. The effective date of the alternative dental insurance determines the cancellation date. There is no appeal to this policy. View the Dental Plan Cancellation webpage.
- That if it is past the deadline and HUSHP Member Services has no record of my application, I can only appeal for coverage with a copy of the application and record that it was received by Member Services.
- Documentation for dependents (e.g., marriage certificate, birth certificate) must be submitted with this application if I have not already submitted it to the medical plan/Harvard University Student Health Program.
- Documentation of my loss of coverage will be required for each member being added for coverage when enrolling due to a loss of other coverage.

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and the termination date of my membership will be determined by Harvard University in accordance with the underwriting guidelines of Blue Cross Blue Shield of Massachusetts. In addition, I authorize the charges to be added to my student account.

Student's Signature _____

Date _____

Please save your completed application and provide documentation of the life-changing event.

Submit this application by 9/30 or within 60 days of the life-changing event via email to HUSHP Member Services at mservices@huhs.harvard.edu

For additional information, please view the Optional Dental Plans Policy and Application webpage.