HUSHP Affiliate Cancellation Policy and Application

POLICY STATEMENT
You may be eligible to cancel the Harvard University Student Health Program (HUSHP) for yourself and or your dependent(s) if you meet the criteria below:

- The cancellation application must be received prior to the start date of coverage for the term you want to cancel (8/1 fall term or 2/1 spring term) or within FIVE business days of submitting your enrollment application
- No services were used for the term in which you are requesting to cancel

☑️ If approved:

- Coverage will be cancelled to the plan effective date for the term you are enrolled
- Both parts of the insurance, the Student Health Fee and the Student Health Insurance Plan will be cancelled
- If applicable a refund will be issued within 20 business days
- Re-enrollment into the plan will be available during the next open enrollment period in which you are eligible to enroll or within 45 days of losing other health insurance coverage (documentation required)
- Appeals to this policy will not be considered
HUSHP Affiliate Cancellation Application

Name: ________________________________________________________________________________________________________________

HUID: ____________________________________________     Telephone: ______________________________________________________

Department: _________________________________________     Email: ________________________________________________________

This application will be processed as follows:

If received prior to the start of the term you are requesting to cancel or within 5 business days of submitting an enrollment application:

- The Student Health Insurance Program will be cancelled, and if applicable, a credit will be issued
- If services were used, you will not qualify to cancel the coverage for that term

If received after the start of a term or beyond the 5 business days of submitting an application

- Only future term(s) of coverage may be cancelled

I am requesting to cancel coverage for the term(s) below

☐ Fall Term (August 1 through January 31)

☐ Spring Term (February 1 through July 31)

☐ Both Terms (August 1 through July 31)

☐ I am requesting to cancel coverage for myself and for all of my dependents

☐ I am requesting to cancel coverage ONLY for the dependent(s) specified below:

Name:______________________________________   Date of Birth:__________________________________

Name:_______________________________________ Date of Birth:__________________________________

Name:_______________________________________ Date of Birth:__________________________________

Name:_______________________________________ Date of Birth:__________________________________

Re-enrollment into the plan will be available during the next open enrollment period in which you are eligible to enroll or within 45 days of losing other health insurance coverage (documentation required)

Signature: ___________________________________________ Date ____________________________________

Office use only:     Accepted By _____________  Processed By _______    Cancellation Date: _____________   Other _________________________