



HUSHP Dependent Cancellation Policy and Application

POLICY STATEMENT

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

- No services were used for the term in which you are requesting to cancel. This includes prescription overrides which allowed your dependents to fill multiple months of medication early.

AND ONE OF THE FOLLOWING CONDITIONS ARE MET:

- The cancellation application is received within **5 business days** of submitting the online enrollment application. Coverage will be cancelled retroactively to the plan effective date for the term you are enrolled.

OR

- The cancellation application is received **prior to the start date of coverage (8/1 fall term or 2/1 spring term)** for the future term you want to cancel. Coverage will be cancelled effective the start date of the **future term** you are enrolled.

OR

- The cancellation application is received within **45 days** of a qualifying event. Coverage will be cancelled retroactively to the day of the event.

Appropriate documentation to support the event is mandatory:

- ✓ **Dependent gaining eligibility:** You can remove dependent(s) who enroll in coverage elsewhere. You must provide a letter from the other employer or insurer indicating your dependents are enrolled or eligible for coverage, the types of coverage they are enrolled in, the names of those enrolled, and the date coverage started. You cannot re-enroll your dependent(s) until the next open enrollment period or within **45 days of losing other health insurance coverage**.
- ✓ **Divorce:** You can remove your former spouse from your coverage. You must provide supporting documentation that your divorce is finalized (copy of the divorce notice). Cancellation will be effective as of the date your divorce is finalized. Your ex-spouse cannot be re-enrolled, not even if required per your divorce agreement. If your spouse is enrolled in your coverage when you divorce, they can remain enrolled as an ex-spouse until the end of that coverage term but will not be allowed to re-enroll for future terms of coverage.

✓ If approved:

- Both parts of the insurance, the Student Health Fee and the Student Health Insurance Plan, will be cancelled
- The applicable credit will be applied to your student bill within 10-20 business days.
- This cancellation request is for dependents only; it will not cancel coverage for the student.
- Re-enrollment 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 Dependent Cancellation Request

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

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

First Name: _____ Last Name: _____

Harvard ID: _____ Email: _____

This application will be processed as follows:

- If services were used by the dependent(s), you will not qualify to cancel the coverage for that term and charges will remain on your student bill.

If received prior to the start of a term or within 5 business days of submitting an online enrollment application:

- The Harvard University Student Health Program will be cancelled, and if applicable, a credit will be applied to your student bill.

If received within 45 days of a qualifying event along with supporting documentation:

- The Harvard University Student Health Program will be cancelled retroactive to the event and if applicable, a credit will be applied to your student bill.

If received after the start of a term or beyond the 5 business days of submitting an online application or beyond the 45 days of a qualifying event or without appropriate documentation to support a qualifying event:

- Dependent cancellation requests cannot be processed for the current term; only future term(s) of coverage may be cancelled.

Cancellation is for [select one]:

- Within 5 business days of submitting enrollment (cancelled retroactively to the plan effective date for the term you are enrolled.)
- Fall Term only (August 1 through January 31)
- Spring Term only (February 1 through July 31)
- Both Terms (August 1 through July 31)
- Due to a Qualifying Event, circle one: Gaining eligibility Divorce

Cancellation is for the following member(s) [select one]:

- I am requesting to cancel coverage for **ALL** of my dependent(s)
- I am requesting to cancel coverage **ONLY** for the dependent(s) specified below:

Spouse/Name: _____ Date of Birth: _____

Child/Name: _____ Date of Birth: _____

Child/Name: _____ Date of Birth: _____

Child/Name: _____ Date of Birth: _____

By submitting this application you acknowledge that you have read and understood the cancellation policy and that re-enrollment into the plan will not be available until the next open enrollment period or within 45 days of your dependent(s) losing other health insurance coverage (documentation required).

Signature: _____ Date: _____

Office use only: Accepted By _____ Processed By _____ Cancellation Date: _____ Other _____