MGH INSTITUTE OF HEALTH PROFESSIONS

Wellfleet Insurance Company - Student Medical Plan
2024-2025 Termination Request Form

USE THIS FORM TO REQUEST TERMINATION FROM THE MGHIHP INSURANCE PLAN. THIS FORM CANNOT BE USED IN PLACE OF THE ONLINE WAIVER FORM. THIS TERMINATION REQUEST FORM IS ONLY FOR STUDENTS WHO ARE CURRENTLY ENROLLED IN THE STUDENT HEALTH INSURANCE PLAN.

STUDENT INFORMATION:

Student Name: (Last)_____ (First)_____ (MI)____ Date of Birth: _____ / _____ / _____

SSN: ____-____-_____ Gender: ___ Email Address: _____Telephone #: ____ - ____ - _____

Mailing Address: (Street Address)_____

(City)_____ (State)_____ (Zip Code)_____

List ONLY the members that for whom you are requesting coverage termination.

PLEASE NOTE:

(1) The "Requested Date of Termination" must be in the future. The plan cannot be terminated retroactively.

(2) Your "Termination Request Form" will not be accepted if there are any paid claims for a Date of Service after your requested Termination Date.

(3) If the plan pays for ANY medical services or prescriptions after the "Requested Date of Termination", your termination date will need to be adjusted. **This will make MGHIHP unable to remove the charge for that semester from your student account.**

PLEASE BE SURE NOT TO USE THE PLAN AFTER THE DATE YOU WOULD LIKE IT TERMINATED.

First Name	Last Name	Date of Birth	Gender	Relationship to Student (Self / Spouse / Child)	Requested Date of Termination

PREMIUM INFORMATION: Early termination **will not** result in a prorated refund of premium. The premium for this plan is only prorated by semester. The semesters during the 2024-2025 Policy Year are 5/1/24-8/31/24, 9/1/24-12/31/24, and 1/1/25-4/30/25. **You will be charged for the full semester in which coverage ends.** *For example, if you are canceling the coverage with a Requested Date of Termination of 9/20/24, you will be charged the full 9/1/24-12/31/24 Student Premium.*

	Per Semester Rate
Student Only	$2,747

VERY IMPORTANT NOTICE TO STUDENTS TERMINATING THEIR COVERAGE: You must demonstrate proof of continuous coverage by completing this page of the form. If this page is not completed properly or is not sent, your MGHIHP Student Health Insurance Plan **will not be cancelled**.

PROOF OF OTHER INSURANCE COVERAGE: Please provide the following information about the plan that will cover you from the day your MGHIHP plan terminates through the end of the current Policy Year (4/30/25).

ALL FIELDS ARE REQUIRED. *If you cannot complete all field, you cannot submit this form.*

Insurance Company Name: _____

Insurance Address: _____

City:_____ **State:**____ **Zip Code:**_____ **Policy or ID #:**_____

Subscriber Name: _____

Subscriber Relation *(choose one)*: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Domestic Partner

SUBMISSION INSTRUCTIONS: To submit your termination request, you may email the two pages of this completed form to **University Health Plans** at:

EMAIL: megan.kearney@univhealthplans.com

By submitting this completed form, you are (1) requesting to terminate your current MGHIHP Student Health Insurance Plan and (2) providing the required "proof of other insurance coverage" information for the remainder of the 2024-2025 Policy Year.

The next policy year begins on 5/1/25. An Enrollment Form or Waiver Form must be filed for EACH policy year. You will be required to fill out the appropriate form for the new policy year when it becomes available.

By signing below, you are agreeing that you have thoroughly read this form and understand its contents.

Student Signature: _____ **Date:** _____

*****If you have any questions, please contact University Health Plans at 833-251-1706 or info@univhealthplans.com.*****