Massachusetts College of Pharmacy & Health Sciences

Student Health Insurance Waiver Appeal Form

MCPHS – Student Financial Services
Attn: Waiver Appeal Committee

Phone: 617-732-2864
Fax: 617-732-2082

You may file a written appeal for consideration of a late waiver if an extenuating circumstance occurred which prevented you from waiving the insurance prior to the September 15th deadline. Please read the information below and complete this form. Please return the form by e-mail to hannimaria.lincoln@mcphs.edu, by fax to 617-732-2082, or directly to Student Financial Services. You should expect to receive notification of approval or denial within 10 business days of the appeal form deadline.

Student Health Insurance Waiver Policies and Procedures for Students

According to the Commonwealth of Massachusetts and MCPHS policy, all Boston, Worcester and Manchester students (regardless of enrollment) must be covered by a comprehensive health insurance program. The College makes available a general health insurance program which meets these standards. This policy is provided by Blue Cross Blue Shield and administered by University Health Plans. The annual coverage begins September 1 and continues 12 months. Students are automatically enrolled in this plan unless a waiver is completed and received by Student Financial Services by September 15th. Students registering late must submit the waiver at that time. This deadline is enforced for benefits administration and enrollment management purposes.

THE DEADLINE FOR FILING THIS APPEAL FORM IS OCTOBER 16, 2011.

In order for your waiver appeal to be considered, all sections must be complete.
Appeals received after the **October 16, 2011** deadline will not be considered.
If you have utilized the insurance coverage, you are not eligible for an appeal or refund.

Student Name: _____

Student ID: _____ **Campus:** _____

Insurance Information: **Name of Insurance Company:** _____

Insurance Type (HMO, PPO, POS): _____ **Telephone Number:** _____

Policy Number: _____ **Group Number:** _____

Subscriber Name: _____ **Subscriber Relationship:** _____

Please use the space below to briefly state the nature of your request and circumstances of your case. Be detailed and specific. Attach documents if necessary.

_____
_____
_____
_____
_____
_____
_____

AUTHORIZATION STATEMENT: By signing this form, I agree to allow the Waiver Appeal Committee to review my situation based on my student account history and above statement. **I understand and agree that the decision of the Waiver Appeal Committee is final and binding.**

_____ _____
Student Signature Date

For Office Use Only: Rec'd __/__/__ ☐ Denied ☐ Approved By: _____ Date: __/__/__ UHP Notified __/__/__ Stu Notified __/__/__