

Brandeis University 2009-2010 Graduate Health Insurance Selection/Reporting Form

All full time and ¾ time students in the Commonwealth of Massachusetts are required by state law to have health insurance while enrolled at any College or University. If you are currently enrolled in the HPHC student Insurance, the Qualifying Student Health Insurance Plan (QSHIP) and want to continue you must complete this form to prevent a lapse in coverage. If you have private insurance, you may decline coverage in SHIP by providing the necessary information below.

Failure to complete this form by the deadline June 26, 2009 will result in an unnecessary charge to your student account.

First/Given Name (print clearly)

MI

Last/Surname (print clearly)

Number & Street Address

City

State

Zip Code

Social Security # or Student Id#

____/____/____
Date of Birth (mm/dd/yy)

Male

Female

1ST Year Grad

Returning Grad

Yes: Enroll me in following Option(s):

Harvard Pilgrim Health Care Student \$1508. Student + Spouse \$6320. Student + Child \$3917.

Family \$8729.00

Dependant names and date(s) of birth _____

Tufts W/RX Student \$5,815.00 Student + One \$ 11,630.00 Family \$17,445.00

Individual Health Center Fee – This annual fee is optional for graduate student's \$612.00 covers visits to the Health Center and the Psychological Center during the academic year. This fee is in addition to your insurance.

No: I do not want to participate in Student Health Insurance Plan.

****ALL INTERNATIONAL INSURANCE COMPANIES MUST HAVE A U.S. ADDRESS****

*Name of Private Insurance Company. _____

*Claims address of Insurance Co. _____

*Customer Service Telephone number. _____

*Group or Plan Number. _____

*Insurance Id Number. _____

*Name of Subscriber/Primary Card Holder. _____

*Subscriber's Social Security# _____

*Students Relationship to Subscriber _____

****Please provide copies of both sides of your private insurance card****

- I certify that I have coverage as indicated above.
- I have determined that my insurance includes all benefits mandated by the Massachusetts Law. I have also determined that my insurance provides me access to health care providers in the area where my school is located
- I have read the above, understand it, and wish to decline enrollment in QSHIP. I further certify that the information provided above is true and complete.

Signature _____

Date

*****Incomplete forms will not be accepted*****