

## Brandeis University 2009-2010 Undergraduate Health Insurance Reporting/Selection 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 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 QSHIP by providing the necessary information below.

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

\_\_\_\_\_  
(Print Clearly) First/Given Name MI (Print Clearly) Last/Surname

\_\_\_\_\_  
(Print Clearly) Number & Street Address

\_\_\_\_\_  
(Print Clearly) City State Zip Code Class of \_\_\_\_\_

\_\_\_\_\_  
Social Security # or Student Id# \_\_\_\_\_  
Date of Birth (mm/dd/yy) \_\_\_\_\_  
 Male  Female  
Brandeis Mailbox (if Known) \_\_\_\_\_

**Yes:** Enroll me in the Harvard Pilgrim Health Care (QSHIP)  
 Student \$1508.00  Student plus Spouse \$6320.00  Student plus Child \$3917.00  Family \$8729.00

Dependant names and date of birth \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

**\*\*International Ins. Companies must have a U.S. address or will not be accepted\*\***

\*Name of Private Insurance Company: \_\_\_\_\_

\*Claims/Billing Address of Insurance Co. \_\_\_\_\_

\*Customer Service Telephone number \_\_\_\_\_

\*Group or Plan Number \_\_\_\_\_

\*Insurance Id Number \_\_\_\_\_

\*Name of Subscriber/Primary Card Holder \_\_\_\_\_

\*Subscriber's Date of Birth \_\_\_\_\_

\*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.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*Incomplete form will not be accepted\*\*\***