

MGH INSTITUTE OF HEALTH PROFESSIONS
Nationwide Life Insurance Company - Student Medical Plan
2010-2011 Termination Request Form

USE THIS FORM TO REQUEST TERMINATION FROM THE MGHHP 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 student's coverage is being terminated, all dependent coverage must be terminated. A spouse/child cannot remain covered if the plan subscriber's coverage is 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 2010-11 Policy Year are 5/1/10-8/31/10, 9/1/10-12/31/10 and 1/1/11-4/30/11. You will be charged for the full semester in which coverage ends. *For example, if you are canceling the coverage for your spouse with a Requested Date of Termination of 9/20/10, you will be charged the full 9/1/10-12/31/10 Spouse Premium.*

Per Semester Rate:

Student Only	\$770
Spouse	\$1,926*
Child	\$1,156*
Children	\$1,926*
Spouse & Child(ren)	\$3,467 *

* Rate does not include Student insurance premium

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 Accident & Sickness 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 (4/30/11). ***ALL FIELDS ARE REQUIRED.***

Insurance Company Name: _____

Insurance Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Policy or ID Number: _____ **Subscriber Name:** _____

Subscriber Relation (circle one): Self Spouse Parent Guardian Domestic Partner

MAILING INSTRUCTIONS: Mail both pages of this form to the following address. You will receive confirmation by email that your termination request has been received and processed. You will also be contacted if there is a problem with your request.

*University Health Plans
One Batterymarch Park
Quincy, MA 02169*

QUESTIONS: If you have any questions, please contact University Health Plans by email at info@univhealthplans.com or by phone at 800-437-6448.

By submitting this completed form, you are (1) requesting to terminate your current MGHIHP Student Accident & Sickness Insurance Plan and (2) providing the required “proof of other insurance coverage” information for the remainder of the 2010-11 Policy Year.

The next policy year begins on 5/1/11. 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:** _____