Tufts UNIVERSITY

Health Sciences Schools

Student Advisory &
Health Administration Office

Health Insurance Waiver Form for Tufts University's Boston & Grafton Campuses 2020-2021

The Commonwealth of Massachusetts and Tufts University Health Sciences Schools require all matriculated students of higher education to participate in a health insurance plan. Complete this form to waive participation in student health insurance plan offered to Tufts University's Health Sciences students for the spring semester March 1, 2021 – August 31, 2021.

Indicate School: Dental Medical Nutrition Public Health Programs Biomedical Sciences Veterinary

Name: _____ **Tufts ID:**_____
Last First Middle

Address:_____ _____
Number, Street, Apt City State Zip Code Date of Birth Gender

Email: _____

Regulation 956 CMR 8.00 Section 8.05 under State Law Chapter 15A, Section 18

Coverage must include: preventive and primary care, emergency services, surgical services, hospitalization benefits, ambulatory patient services and mental health services. The services covered must be accessible in the area where the school is located.

1.	Is your policy underwritten by a United States based company?	**Yes**	**No**
2.	Does your plan provide mental health care benefits in the Massachusetts area?	**Yes**	**No**
3.	Does your plan provide preventive; primary care; and ambulatory patient services in the Massachusetts area?	**Yes**	**No**
4.	Does your plan provide emergency care benefits in the Massachusetts area?	**Yes**	**No**
5.	Does your plan cover inpatient hospitalization and both inpatient and outpatient surgical services in the Massachusetts area?	**Yes**	**No**
6.	Is your health plan carrier Kaiser Permanente?	**Yes**	**No**

Insurance Company's Name _____

Policy Number_____ **Insurance Company's State** _____

Policyholder's Name_____ **Relationship to Student** _____

I certify that I am covered by the insurance policy listed above for the academic year beginning on September 1, 2020 and ending August 31, 2021. I also certify that this policy is comparable to the minimum coverage required by the Commonwealth of Massachusetts. I understand that by completing this Waiver, I am responsible for my medical expenses, and neither Tufts University nor the University's health insurance carrier will be responsible for those expenses.

I understand that the school health insurance covers all needlestick injuries and/or other exposures to bloodborne pathogens. By waiving the school health insurance, I understand that my plan may or may not cover me for needlestick injuries and/or other exposure to bloodborne pathogens. I understand that if I waive the school health insurance, I am responsible for my medical expenses and neither Tufts University nor the University's health insurance carrier will be responsible for those expenses.

I understand that the school health insurance covers rabies pre-exposure vaccines, titer-testing, rabies booster vaccines, and post-exposure treatment. By waiving the school health insurance, I understand that my plan may or may not cover me for rabies pre-exposure and post-exposure treatment. I understand that if I waive the school health insurance, I am responsible for my medical expenses and neither Tufts University nor the University's health insurance carrier will be responsible for those expenses.

UHCSR Plan Coverage: Individual Two-Person Family Plan

- **Signature:**_____ **Date:** _____

Return form to the Student Advisory & Health Administration Office by email to Cynthia.Linton@tufts.edu