THE DEADLINE FOR FILING THIS APPEAL FORM IS OCTOBER 31, 2016.
In order for your waiver appeal to be considered, you must complete all of the information on the appeal form and include a copy of your valid health insurance ID card.

Student Health Insurance Waiver Appeal

For Fisk University

Term 8/1/2016 – 7/31/2017

You may file a written appeal for consideration for late insurance waiver if a processing error by your college or an extraordinary personal circumstance occurred which prevented you from taking action during the published waiver period. Please read the information below and then complete this form. Return by fax to 413-747-8418 or mail to Consolidated Health Plans, Attn. Sales and Marketing, 2077 Roosevelt Avenue, Springfield, MA 01104. You should expect to receive notification of approval or denial within 10 business days of receipt.

Student Health Insurance Program Waiver Appeal Policies & Procedures for Students

Students must withdraw from the Student Health Insurance Program prior to the 1st day of their initial academic term each year. For Students enrolling in the Annual 2016 plan, the deadline to waive the insurance was August 30, 2016. This deadline is the end of the waiver period when students have the option to opt out of the Fisk Student Health Insurance Plan. Students may only withdraw from coverage in their 1st term of enrollment each academic year. This deadline is strictly enforced for benefits administration and enrollment management purposes.

Late Withdrawal:

- Your account shows you did not waive Student Health Insurance during your registration period for this term.
- Changes to your insurance coverage should have been made by the August 30, 2016 deadline for your initial term of the academic year.
- You must file this appeal no later than **October 31, 2016.** If the form is not received by that deadline, the Student Health Insurance Fee will remain on your account, and you have Student Health Insurance coverage for the term.

➔PLEASE PRINT LEGIBLY←

SECTION I

School: Fisk University Student ID _____

_____ _____/_____/_____
Student's Last Name First MI Date of Birth

_____
Address Apt. # City State Zip

E-mail_____ Telephone (_____) _____-_____

SECTION II

Please read and check the box acknowledging that you have read and understand.

☐ **I am requesting late waiver from the Student Health Insurance Program for Fisk University. I have not utilized the Student Health Insurance Program (incurred health claims) for this coverage period. I understand this request will not be honored if claims have been paid. I understand there is no pro-ration of the premium (the coverage period will not be in effect for the entire term/coverage period) and I waive the Student Health Insurance Program coverage for this term if approved. I HAVE INCLUDED A COPY OF MY HEALTH INSURANCE CARD TO PROVE THAT I HAVE COMPARABLE COVERAGE FOR THE TERM INDICATED.**

_____ _____/_____/_____
Signature of Student Date

SECTION III

Use the space below to briefly describe the school error or personal circumstance which prevented you from withdrawing by the deadline. Attach documents to substantiate your request.

_____
_____
_____

For Office Use Only

Rec'd _____/_____/_____ ☐ Denied ☐ Approved ☐ N/A ☐ By: _____ Date _____/_____/_____ Reason_____

School notified _____/_____/_____ Student notified _____/_____/_____ Email ☐ Letter ☐ Both ☐