

Dartmouth Student Group Health Plan

7 Rope Ferry Road #6143, Hanover NH 03755

Telephone # (603) 646-9438 & (603) 646-9439

Email: Dartmouth.Student.Health.Plan@Dartmouth.EDU

Website: <http://www.dartmouth.edu/~health/depts/insurance/index.html>

Name: _____

DC ID # _____ Class: _____

Submission Deadline: _____

2009 – 2010 DSGHP Mid-Year Enrollment & Insurance Waiver Petition

Please complete and return this form to the address shown above.

ENROLLMENT: You have been enrolled into the Dartmouth Student Group Health Plan (DSGHP) for the following timeframe.

_____ to _____. Fee is \$_____.

You were enrolled later than September 1, 2009 because:

_____ Dartmouth sponsored study abroad program.

_____ Mid year start date, term: _____

_____ My coverage with another health plan was terminated involuntarily (Please provide documentation showing involuntary loss of coverage. You must submit this application within 31 days of termination with the other plan.)

_____ Other (please explain) _____

I understand that I will automatically be re-enrolled into the plan and the fee charged to my student account each year I am eligible and that if I wish to waive enrollment I need to submit a completed waiver by the deadline. I also understand that my enrollment can not be cancelled except with an advanced written application to terminate December 31 or March 31, as described in the DSGHP Plan Document found at the website below.

Dependent Applications are available at: <http://www.dartmouth.edu/~health/depts/insurance/index.html>

Download, print, complete, and submit the dependent application to the DSGHP Office with this enrollment petition by the deadline if you have dependent's you would like to enroll into the plan for an additional fee.

WAIVER PETITION: I wish to waive DSGHP coverage because I have health insurance that is certified by my insurance plan representative to satisfy the six (6) coverage conditions described below. **Note: Your representative must provide six (6) YES responses below and sign this form for your waiver to be approved.**

Insurance Company Name: _____

Claim Submission Address: _____

Member ID#: _____ **Group or Plan#:** _____

Subscriber (Employee name, not employer name): _____

USA Question or Claim Inquiry Phone Number: _____

YES NO

- 1. The plan includes Dartmouth Hitchcock Medical Center (www.dhmc.org) and its affiliated physicians as in-network providers and/or provides in-network level benefits for both emergency and non-emergency health care services received in the Hanover, NH area. (Plans that provide only emergency coverage in the Hanover, NH area do not meet this requirement.)
- 2. The plan provides coverage for inpatient and outpatient mental health care and chemical/substance abuse treatment. Benefits include at least thirty (30) outpatient mental health visits in the Hanover, NH area.
- 3. The maximum benefit for the coverage is \$500,000 or more per year.
- 4. The plan covers (i.e. there is no exclusion or limitation for participation in high-risk activities or sports) expenses incurred in the United States and abroad for participation in varsity intercollegiate sports (including practice sessions), club sports or intramural sports, and for participation in Dartmouth College sponsored or provided activities (e.g. Dartmouth Outing Club outdoor activities).
- 5. The plan will remain in force as long as the student remains active (including on an approved leave of absence, leave term, or pending graduation) for the plan year beginning September 1st, 2009 and ending August 31st, 2010.
- 6. The plan is licensed to do business in the United States of America (USA), has a USA-based claims processor, and a USA telephone number.

IMPORTANT: SIGNATURE OF INSURANCE REPRESENTATIVE REQUIRED FOR WAIVER APPROVAL.

Signature of Official representing your Employer Benefits Office or Insurance Co. _____ Official's Title and Agency _____ Date _____

Please sign and return to DSGHP Office at address above.

Student _____ Date _____ Parent or Guardian (if student under 18) _____ Date _____

Office Use Only:

Approved: Ins. _____ Ledger: _____ Ack: _____ **Denied:** Ins.: _____ D-Ack: _____

2009 – 2010 Dartmouth Student Group Health Plan Waiver Instructions

- 1) Verify that the student name, Dartmouth College identification number and class at the top of the waiver are correct.
 - a. If any of the information is incorrect, draw a single line through the incorrect information and write in the correct above or below it.
- 2) Fill in the insurance company name, claim address, complete member identification number (be sure to include any letters, dots or dashes that may be part of it), group number, subscriber name, and inquiry phone number. This information is located on your insurance identification card.
 - a. If unsure of what information is needed you may submit a copy of your insurance identification card along with the completed waiver petition.
- 3) Bring, or forward, the waiver petition to your Employer Benefits Office or Insurance Company and have them answer yes or no to the six coverage conditions, sign, fill in their job title, the agency they work for and the date they signed.
 - a. We will accept a letter from your Employer Benefits Office or Insurance Company providing the policy information is included, the six conditions are specified and the letter is signed.
 - b. Any missing information will either cause a delay in the processing of your waiver or for the waiver to be denied.
 - c. A copy of your insurance coverage plan document does not meet the waiver requirement.
 - d. We highly recommend that you make a copy of the waiver for your records before mailing it to us.
- 4) Submit the completed waiver petition to the Dartmouth Student Group Health Plan Office by August 1 for those starting Fall 2009, or the first day of the term for those starting Winter, Spring or Summer terms.
 - a. Mailing Address: 7 Rope Ferry Road, HB# 6143, Hanover, NH 03755
 - b. Office Drop Off: Rooms 112 and 112A of Dick's House (first floor, just past the Pharmacy)
 - c. Fax: 603-646-9450
 - d. E-mail: Dartmouth.Student.Health.Plan@Dartmouth.EDU
- 5) The Dartmouth Student Group Health Plan Office will notify you in writing by domestic US mail when your waiver has been received and reviewed. Please allow two weeks from our receipt date for our response to reach you.
- 6) As our phone, lines are extremely busy during July and August for your convenience we have created a listing of frequently asked questions. This list is available on-line at <http://www.dartmouth.edu/~health/depts/insurance/index.html>.
- 7) If you believe you have received this waiver petition in error contact the DSGHP Office immediately.
 - a. E-mail: Dartmouth.Student.Health.Plan@Dartmouth.EDU
 - b. Phone: 603-646-9438 and 603-646-9439