

**2020-2021 Salem State**  
**Late Appeal Request Form**

The Fall waiver deadline was September 25th and a late waiver period was held until October 26th. Spring waiver deadline is February 26th and a late waiver period was held until May 5th. Numerous reminder emails were sent. If you had extenuating circumstances and could not waive during the waiver period complete the form below for review. Completing the form does not guarantee your waiver will be accepted. Once complete, please email this form to NavCenter@salemstate.edu.

**Please answer the following:**

1). Does your plan provide coverage for medically necessary care in the Salem/Greater Boston area, and out of state? (Required to waive.)

Yes  No

2). Does your insurance provide coverage for the entire academic year without restrictions? (Required to waive.)

Yes  No

3. Is your plan a Health Safety Net, MassHealth Limited or Children's Medical Security Plan? (If you have one of these plans you are not eligible to waive the student health insurance plan and you should notify them immediately that you are enrolling in the Salem State Student Health Insurance Plan.)

Yes  No

4. Does your plan include mental health services? (Required to waive.)

Yes  No

5. Are you an international student on a **J1** or **F1** visa? (Salem State College requires all international students on **J1** or **F1** visas to enroll in the Student Health Program or SHP, unless they are covered under a family member's U.S.-based insurance plan.)

Yes  No

**Please complete the following:**

Student Name:
Student ID:
Email Address:
Date of Birth:
Provide a brief explanation as to why you could not waive before the waiver period closed:

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Insurance Company Name:
Member ID Number:
Policy Number:
Source of Insurance — select one <input type="checkbox"/>
Employer. If employer, specify employer's US State: <input type="checkbox"/>
Medicaid. If Medicaid, specify Medicaid state: <input type="checkbox"/>
Travel plan. <input type="checkbox"/>
Not listed. If not listed, specify your source of insurance:
Subscriber Name:
Subscriber ID:
Subscriber DOB:
Subscriber Relationship to Student:

By signing below, I affirm that:

1. The insurance information supplied above is correct and I have health insurance coverage that meets all conditions previously confirmed;
2. I understand that I am legally responsible for any medical expenses incurred during my enrollment in Salem State University and that the University and its Student Health Insurance Plan will not be held responsible for any of my medical expenses once I waive coverage; and
3. I understand that neither the school nor the Student Health Program will be responsible for any of these medical expenses.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Authorized by:**

\_\_\_\_\_  
Salem State Representative

\_\_\_\_\_  
Date