2025-2026 Salem State

Late Appeal Request Form

The Fall waiver deadline was September 26th and a late waiver period was held until October 27th. Spring waiver deadline is January 30th and a late waiver period was held until April 29th. 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:

Please confirm the insurance you are trying to waive: ☐ **Annual** ☐ **Spring Only**

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 **FI** visa? (Salem State College requires all international students on **J1** or **FI** 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 ☐ Employer. If employer, specify employer's US State:
☐ Medicaid. If Medicaid, specify Medicaid state:
☐ Travel plan. ☐ 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