Health and Dental Opt Out Appeal Form

Memorial University of Newfoundland Students' Union
UC 2000 | Memorial University of Newfoundland | St. John's, NL | A1C 5S7
Tel: (709) 737-7633 | Fax: (709) 737-4743

Name: _____ Date: _____

Student Number: _____ Phone: _____

Mailing Address: _____ e-mail: _____

_____

_____

_____

Please note your enrollment status during the year for which you wish to opt out:

	Full Time	Part Time	Work Term	Not Enrolled
Fall:	☐	☐	☐	☐
Winter:	☐	☐	☐	☐
Spring:	☐	☐	☐	☐

Opt-Out Appeal Guidelines:

Students who wish to opt out of the MUNSU Health and Dental Plan, but missed the opt-out deadline, can submit an appeal for consideration by the Finance and Services Committee.

All appeals must include:

- An opt-out appeal form, completed in full.
- A short, concise letter explaining the reason for the appeal, detailing why the opt-out deadline was missed.
- Proof of coverage under an alternative health and dental insurance plan.

All appeals must be submitted by the student. Appeals completed by any other person will not be considered.

Appeals that are illegible will not be considered. Portions of the appeal that include handwriting are asked to be printed neatly in blue or black ink.

If you have any questions about the process, please contact frontdesk@munsu.ca.

MEMORIAL UNIVERSITY OF NEWFOUNDLAND STUDENTS' UNION
HEALTH AND DENTAL PLAN

Waiver of Participation- For Students with Alternate Coverage

I wish to decline participation in the health and/or dental portion(s) of the Memorial University of Newfoundland Students' Union Health and Dental Plan (the "MUNSU Health and Dental Plan"). Comparable coverage is presently provided for me under another plan ("Alternate Coverage"), in addition to my provincial health insurance. I acknowledge that as a result of this waiver I forfeit all rights to coverage otherwise available to me under one or both parts of the MUNSU Health and Dental plan as indicated below.

I realize that I will be unable to participate again until I register for studies in the first academic semester in which I am enrolled in the next plan year. Furthermore I understand that I would have been able to claim under both my alternate coverage and portions of the MUNSU Health and Dental Plan I am hereby waiving.

In the event that I lose my alternate coverage, I may make application to participate in the portion of the MUNSU health and dental plan, hereby waived, within 31 days immediately following the loss of my alternate coverage.

PLEASE PRINT

Student Name: _____ **Student #:** _____

Student Signature: _____ **Date:** _____

Details of Alternate Coverage

Documentation of alternate coverage clearly displaying the name of the insurance company providing the alternate coverage along with the policy number must be shown at time of submission. It must contain the detail as to the type of coverage (saying health and/or dental as applicable). Acceptable documentation includes a certificate, insurance policy, a letter from the plan sponsor, or membership card.

☐ HEALTH **POLICY #** _____ **PROVIDER:** _____

☐ DENTAL **POLICY #** _____ **PROVIDER:** _____

MUNSU APPROVAL: _____ DATE: _____

THIS FORM, WITH ATTACHED DOCUMENTATION OF ALTERNATE COVERAGE AS OUTLINED ABOVE, MUST BE RETUREND TO THE MUNSU OFFICE NO LATER THAN TWO WEEKS AFTER THE FIRST DAY OF LECTURES