2024-2025

Dartmouth Student Group Health Plan (DSGHP)
Mid-Year Cancellation Application

Dartmouth Student Group Health Plan
Mailing Address:
7 Rope Ferry Rd, HB# 6143
Hanover, NH 03755

E-mail: dartmouth.student.health.plan@dartmouth.edu
Website: http://www.dartgo.org/studentinsurance
Telephone: (603) 646-9438 & (603) 646-9449 Fax: (603) 646-8893

Student Name: _____ Class: _____ Dartmouth ID#: _____
Last First

Cancellation Option #1

I wish to cancel my Dartmouth Student Group Health Plan (DSGHP) coverage effective: (check one)

( ) December 31, 2024, completed application due by December 15, 2024. ( ) March 31, 2025, completed application due by March 15, 2025.

I qualify for cancellation of my DSGHP coverage as one of the following pertain to my situation: (check one)

( ) I have completed my degree requirements at the end of Fall or Winter Term.
(A letter from my Registrar certifying completion is attached.)

( ) I have withdrawn or separated from the College.
(A notice of withdrawal or separation from my Dean's office is attached.)

( ) I have other insurance that meets Dartmouth's insurance requirements.
(Online waiver has been approved.)

( ) I, or my dependent, have entered into the Armed Services of any country.
(A copy of my, or my dependent's, active duty orders is attached.)

I understand that the DSGHP premium will be prorated effective the date of cancellation. I authorize the DSGHP Office, to charge any balance owed or to credit any overpayment by me on the prorated premium for the period covered through the cancellation date, to my student tuition account. I understand that by signing this application, I am authorizing the DSGHP Office to terminate my coverage, and my dependent's coverage (if applicable), on the date indicated above. I also understand that my spouse or domestic partner's eligibility to receive services at Dick's House will terminate on the same date as their DSGHP coverage.

Student Signature:_____ Date:_____

Dependent Signature (required if over 18):_____ Date:_____

Cancellation Option #2

I wish to cancel my dependent's DSGHP coverage: (check one)

( ) December 31, 2024, completed application due by December 15, 2024. ( ) March 31, 2025, completed application due by March 15, 2025.

Dependent Name: _____ Date of Birth: _____ Relation: ( )spouse ( )DP ( )child

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Dependent Name: _____ Date of Birth: _____ Relation: ( )spouse ( )DP ( )child

I understand that the family premium will be prorated effective the date of cancellation. I authorize the DSGHP Office to charge any balance owed or to credit any overpayment by me on the prorated premium for the period covered through the cancellation date to my student tuition account. I understand that by signing this application I am authorizing the DSGHP Office to terminate my dependent's coverage on the date indicated above. I also understand that my spouse or domestic partner's eligibility to receive services at Dick's House will terminate on the same date as their DSGHP coverage.

Student Signature: _____ Date: _____

Dependent Signature (required if over 18): _____ Date: _____