



AMHERST COLLEGE

Office of Financial Aid

B-5 Converse Hall
P.O. Box 5000
Amherst, Massachusetts 01002-5000

Telephone (413) 542-2296
Facsimile (413) 542-2628

Request for Amherst College Scholarship – Health

*Amherst College requires that all students either participate in the College's health insurance plan or have comparable medical insurance coverage. If you are already covered by your family's insurance, it is expected that you will continue to be covered by it. Note that health insurance coverage provided through a state Medicare program may **not** be available outside of the state. Likewise, coverage provided by a health maintenance organization (HMO) may not be available outside its immediate service area.*

*"Amherst College Scholarship – Health" funds are available to Amherst College Scholarship recipients who (with their parents, as applicable) **certify to the Office of Financial Aid that they are not covered by their family's insurance or do not have substantially equivalent coverage available to them in Massachusetts.** If this is your circumstance, complete this form and return it to the Office of Financial Aid. Your student expense budget and financial aid will be adjusted by the cost of the College's student health insurance plan. Such scholarship assistance is taxable to you under the Internal Revenue Code.*

Student's Name: _____

Class: _____

I request that scholarship assistance be provided to cover the cost of the College's student health insurance plan for the period August 15, 2023, through August 14, 2024. I make this request for the following reason. (Check appropriate box.)

- ☐ I am not currently covered by any health insurance plan under either my name or a parent's name.
- ☐ I have compared the health insurance plan in which I am currently participating with Amherst College's student health insurance plan and have determined that the benefits are not substantially equivalent or are not available to me in Massachusetts. (Please explain.)

- ☐ I also confirm that I have not completed the health insurance waiver process or that a health insurance waiver has been denied.

Student's signature: _____ Date: _____

Parent's signature (**REQUIRED**): _____ Date: _____