Students who failed to complete an insurance waiver by the published deadline, but are currently enrolled on another insurance plan, should complete this form and return it to the student insurance office located in the Hartshorn building, lower level, or email it to CSUHN_Insurance@mail.colostate.edu, or fax it to (970) 491-6965 immediately.

In addition to this appeal form, students will be required to provide proof of current enrollment in an outside insurance plan. Please submit a copy of the front and back of your current insurance card. If this is an Individual Health Plan, you must also submit a copy of the Schedule of Benefits for this plan. This plan must be written in English, converted to US dollars and must contain a schedule of benefits and a list of the policy exclusions.

### SECTION A : Student Information

<table>
<thead>
<tr>
<th>PLEASE SELECT:</th>
<th>Domestic Student</th>
<th>International Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST NAME</td>
<td>FIRST NAME</td>
<td>MI</td>
</tr>
<tr>
<td>EMAIL ADDRESS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHONE NUMBER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PLEASE ANSWER THE FOLLOWING QUESTIONS OR MARK APPROPRIATE BOXES REGARDING YOUR INSURANCE POLICY:**

- **SELECT TYPE OF PLAN:**  
  - [ ] INDIVIDUAL  
  - [ ] EMPLOYER GROUP PLAN

- **NAME OF THE INSURANCE PROVIDER:**

- **INSURANCE PHONE NUMBER:**

- **NAME OF THE PRIMARY INSURED:**

- **RELATIONSHIP TO PRIMARY INSURED:**  
  - [ ] SELF  
  - [ ] PARENT  
  - [ ] SPOUSE

- **EFFECTIVE DATE OF COVERAGE:**

- **STUDENT SIGNATURE**  
  

**DATE**  

/  

/  

**PLEASE PROVIDE AN EXPLANATION AS TO WHY THIS INFORMATION WAS NOT PROVIDED BEFORE THE PUBLISHED DEADLINE AND WHY YOU FEEL AN APPEAL SHOULD BE GRANTED IN YOUR CASE:**

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You will be notified via email once your appeal has been processed. Please allow 20 business days for processing.

**Office use only:**  
Appeal Approved  
Appeal Denied  
Date