

UC DAVIS STUDENT HEALTH INSURANCE PLAN (UC SHIP)

Request to Cancel Waiver

LAST NAME	FIRST NAME	MI	STUDENT IDENTIFICATION NUMBER	DATE OF BIRTH
UC DAVIS EMAIL ADDRESS				TELEPHONE NUMBER

CHECK ONE:

Undergraduate Student

Graduate Student (Quarter)

Graduate Student (Semester)

I am requesting to cancel my UC SHIP waiver. I understand that I will NOT be allowed to waive UC SHIP again during the current academic year.

The cancellation will be effective the date this request is received, or a future date specified here:

Effective Starting Date: _____

I understand that UC SHIP coverage for quarters or semesters in progress will start on the effective date specified on this waiver cancellation request. I will be responsible for a full quarter (semester) UC SHIP fee, as UC SHIP fees are not prorated. The UC SHIP fee will be billed to my student account. I understand that I will remain enrolled in UC SHIP and will not be allowed to waive for the rest of the current academic year.

Reason for Cancellation: _____

SIGNATURE

DATE

Return to:

Insurance Services Office
Student Health and Wellness Center
University of California, Davis
Davis, CA 95616-8711
Email: waiver@shcs.ucdavis.edu

Hours of Operation:
M-T-Th-F 8 am-5 pm
Wed 9 am-5 pm
FAX: (530) 752-7679

<i>Office use only:</i>		
_____	_____	<input type="checkbox"/> Graduate Student Qtr
date cancelled	effective date	<input type="checkbox"/> Graduate Student Sem
_____	\$ _____	<input type="checkbox"/> Undergraduate Student
initials	student account charged	