

UC SHIP Waiver Application 2026-27

This form is only valid for the applicable terms of the 2026-27 academic year.

Instructions: Please Read and Acknowledge

1. Complete the entire application. Incomplete applications will be returned to you and not processed.
2. Attach proof of active coverage from your insurance company, dated within the last 30 days.
 - a. This can be in the form of a letter or email from your insurance company's customer service department, or a screenshot of your online member portal that shows your coverage is currently active.
3. Attach a copy of your current insurance ID card (front and back)
4. Attach a copy of the summary of benefits and coverage (SBC) for your insurance plan
 - a. Students enrolled in Medi-Cal, Tricare/Military, or Kaiser Permanente are not required to submit this documentation.
5. Students with an HMO plan must include documentation that shows they have an assigned primary care provider within 50 miles of campus.

Acknowledgement: I have read and understand the above instructions.

Signature:

Date:

Deadlines:

Fall Semester: August 15, 2026

Fall Semester Late Waiver: September 15, 2026 (Subject to \$50 late fee)

- Approved waivers applied to Fall and Spring semesters

Spring Semester: December 1, 2026

Spring Semester Late Waiver: January 1, 2027 (Subject to \$50 late fee)

- Approved waivers applied to Spring semester only

Summer Term: Please contact your program for your summer term waiver deadline

Fall Quarter: September 1, 2026

Fall Quarter Late Waiver: October 1, 2026 (Subject to \$50 late fee)

- Approved waivers applied to Fall, Winter, and Spring quarters

Winter Quarter: December 1, 2026

Winter Quarter Late Waiver: January 1, 2027 (Subject to \$50 late fee)

- Approved waivers applied to Winter and Spring quarters only

Spring Quarter: March 1, 2027

Spring Quarter Late Waiver: April 1, 2027

- Approved waivers applied to Spring quarter only

Student Information:

Academic Level:

- Undergraduate Student
- Graduate Student
- Graduate Student – School of Law
- Graduate Student – School of Vet Med
- Graduate Student – School of Medicine

Student ID Number:

Date:

Student Last Name:

Student First Name:

UC Davis Email Address:

Date of Birth:

Insurance Plan Information:

Name of Insurance Company:

If Medi-Cal, please provide what county your coverage is currently active in:

Insurance ID Number:

Insurance Company Phone Number:

Primary Subscriber Name:

Primary Subscriber Date of Birth:

Insurance Plan Benefits: Please answer the following questions

1. Does your health insurance plan provide unrestricted access to an in-network hospital or doctor, providing full, non-emergency medical and behavioral health care within 50 miles of campus or the student's place of residence while attending school?
 - a. YES
 - b. NO
2. Does your plan have an annual out of pocket maximum of \$10,600 or less for an individual, or \$21,200 or less for a family?
 - a. YES
 - b. NO

3. Does your health insurance plan cover all of the following services?
- a. Inpatient hospital and outpatient care for mental health and substance abuse disorder conditions the same as any other medical condition.
 - i. YES
 - ii. NO
 - b. Doctor office visits for medical care, including mental health and alcohol/drug abuse conditions.
 - i. YES
 - ii. NO
 - c. Provides coverage for all Minimum Essential Health Benefits. For a list of the current minimum essential health benefits, please see:
<https://www.cms.gov/marketplace/resources/data/essential-health-benefits>
 - i. YES
 - ii. NO
4. Is your health care or pharmacy coverage a reimbursement plan? Reimbursement plan means the student must pay for services and then seek reimbursement from the insurance provider.
- a. YES
 - b. NO
5. Does your plan have a per-medical or per-mental health/substance use condition maximum dollar limit?
- a. YES
 - b. NO

International Student Only – Please answer the following questions about your health insurance plan:

- 1. Does your plan have a per-medical or per-mental health/substance use condition maximum benefit limit?
 - a. YES
 - b. NO
- 2. Does your plan cover services related to suicidal conditions, including attempted suicide or suicidal thoughts?
 - a. YES
 - b. NO
- 3. Does your plan cover medical services for injury from participation in all types of recreational activities or amateur sports?
 - a. YES
 - b. NO
- 4. Does your plan have a pre-existing condition exclusion or limitation?
 - a. YES
 - b. NO
- 5. Does your plan have a lifetime maximum on benefits?

- a. YES
- b. NO
6. Does your plan have a complete master policy written in standard English with benefits expressed in U.S. dollars?
- a. YES
- b. NO
7. Does your plan have a claims payment office with an address and phone number in the United States?
- a. YES
- b. NO
8. Does your plan pay at least \$50,000 annually for medical evacuation from the United States to the student's home country?
- a. YES
- b. NO
9. Does your plan pay at least \$25,000 for repatriation of remains from the United States to the student's home country?
- a. YES
- b. NO

Acknowledgements:

By initialing the statements below, and electronically signing at the bottom of this document, I acknowledge the following:

- I request a waiver of participation for the university student health insurance plan (UC SHIP). I acknowledge that I am legally responsible for any and all medical expenses during my enrollment at UC Davis, and that UC Davis will not be responsible for any medical expenses I may incur. I agree that I will maintain health insurance at all times during the waiver period. If I do not for any reason, I will notify the Insurance Services office immediately. By submitting this form, I attest that the information provided about my health insurance coverage is true and correct.

(Initial)

- I acknowledge that if my waiver request is approved, this waiver of enrollment in UC SHIP is valid until next Fall term, at which time, I am required to request to waive enrollment in UC SHIP again if I still have health care coverage that meets UC's waiver criteria.

I must re-apply to waive enrollment in UC SHIP prior to the start of each Fall term.

(Initial)

Student Comments: If you have any additional information you would like to share for the Insurance Services Staff to process your application, please use this space.

How to Submit Your Application:

You can submit your waiver application and all of the required documentation in the following ways:

- Email: waiver@shcs.ucdavis.edu
 - In Person: Insurance Services Office, 3rd Floor, Student Health and Wellness Center
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- Applications submitted using this form can take up to 30 days to be processed.
 - Applications are processed in the order in which they are received.
 - If you email the application and documentation, please only do so once.
 - Each time you send an additional email, it may reset the 30 day processing time.
 - If you have any questions about the waiver process, please contact the Insurance Services department via email at waiver@shcs.ucdavis.edu

IMPORTANT NOTICE: Waiver applications are subject to audit. Students may be asked to provide additional documentation regarding their health insurance plan. If the coverage information provided does not meet the university's current waiver criteria and this request fails to pass audit, students will be enrolled in UC SHIP and charged the premium fee for the full coverage period to their campus account.

Please acknowledge that you have read and understand the above information by entering your name and date here:

Student Signature:

Date:

If a person other than the student is completing this form, please enter your name and relationship to the student applying for this request to waive enrollment in UC SHIP.

Name:

Relationship to Student:

For Office Use Only:

Approved:

Denied:

Processed By:

Date: