UC Davis Student Health Insurance Plan (UC SHIP)
Waiver Application 2021-2022
QUARTER STUDENTS (Graduate and Undergraduate)
INSTRUCTIONS – Please read and confirm before continuing

1. **Make a copy** of your completed waiver application and retain it as your receipt.
    a. The burden of proof that a waiver application was submitted resides with the student.
2. **What you will need to submit the waiver for review:**
    - The completed waiver application
    - A copy of your current insurance ID card (front and back)
    - A copy of the summary of benefits for your plan, which gives a short description of the basic benefits of your coverage.
    - Proof of eligibility, which can be in the form of a letter from the insurance company, or a screenshot from your online portal showing that your plan is active.

3. **You can submit the application and all documentation in the following ways:**

    Email: waiver@shcs.ucdavis.edu

    Fax: (530) 752-7679

PLEASE BE AWARE:

a) Incomplete waiver applications will not be processed.

b) Paper waiver applications may take up to 30 days to be processed.

If you have any questions about the waiver process, please contact the Insurance Services department via email at waiver@shcs.ucdavis.edu

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Things to remember:

- A new waiver application needs to be completed prior to the start of each new academic year
- You can cancel your approved waiver at any time during the academic year to enroll in UC SHIP

****Initial here to acknowledge that you have read and understand all of the above: _____**

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PART I – Student Information

Student ID Number: _____ Telephone Number: _____

Name (Last, First): _____

UC Davis Email Address: _____ Date of Birth: _____

PART II – Insurance Plan Information

Name of Insurance Company: _____ Insurance ID #: _____

Insurance Group Number: _____ Insurance Company Phone #: _____

Primary Subscriber: _____ Primary Subscriber Date of Birth: _____

If Medi-Cal, please list which county your coverage is active in: _____

PART III – Insurance Plan Benefits

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 175 miles of campus or the student's place of residence while attending school?**
   - ☐ YES
   - ☐ NO
2. **Does your plan have an annual out-of-pocket maximum of $8,150 OR LESS for an individual or $16,300 OR LESS for a family?**
   - ☐ YES
   - ☐ NO
3. **Does your health insurance plan cover all of the following services?**
   - Inpatient (hospital) and outpatient care for mental health and substance abuse disorder conditions the same as any other medical condition
   - Doctor office visits for medical, including mental health, and alcohol/drug abuse conditions
   - Provides coverage for all Minimum Essential Health Benefits. For a list of the current minimum essential health benefits, please see: https://www.cms.gov/cciio/resources/data-resources/ehb.html

   - ☐ YES
   - ☐ NO
4. **Is your health care plan based on reimbursement of your expenses paid at the time of service for medical care? (Under this type of plan, you pay for medical, pharmacy and behavioral health services out of your own pocket and obtain reimbursement afterwards from another party.)**
   - ☐ YES
   - ☐ NO

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Part V – Acknowledgements

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

- I request a waiver of participation for the university student health insurance plan. 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 Insurance Services immediately. By submitting this form, I attest that the information provided about my health insurance coverage is true and correct. _____(initial)

- I agree to provide a copy of my health insurance identification card or other documentation as requested by the university or its agent. I understand that if I fail to provide documentation upon request, I will be enrolled in UC SHIP and premium for the full coverage period will be billed to my student account. _____ (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)

DEADLINE for Quarter Students (submit by)	Approved waiver applies to the following quarters
September 1, 2021	Fall, Winter and Spring Quarters
December 1, 2021	Winter and Spring Quarters Only
March 1, 2022	Spring Quarter Only

IMPORTANT NOTICE: Your waiver application will be subject to audit for which you may be asked to provide additional information regarding your health insurance plan. If the coverage information you provide does not meet the university's criteria and this request fails to pass the audit, you will be enrolled in UC SHIP and charged the premium fee for the full coverage period on your campus account.

Please verify that you have read and understood these acknowledgements by entering your name 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 ☐ By: _____ Date: _____

Fall Qtr. ☐ Wtr Qtr. ☐ Spring Qtr. ☐