

Insurance Waiver Reversal / Enrollment Form

UCSC Student Health Services
 Student Health Insurance Department
 1156 High Street
 Santa Cruz, CA 95064

Phone: (831) 459-2389, Option #2
 Fax: (831) 459-4050
 E-mail: insure@ucsc.edu
 Web: <http://healthcenter.ucsc.edu>

Waiver Reversal / Enrollment Request

The Waiver Reversal / Enrollment Request is intended for students who have waived out of the UC Student Health Insurance Plan (UC SHIP) and now wish to enroll or re-enroll.

If the Waiver Reversal / Enrollment Request is approved, we will post the insurance premium charges on your student account and you should see that on your next billing statement. In addition, you will be charged the premium for each subsequent quarter in the academic year. The effective date will be the date this form was signed. We cannot pro-rate Waiver Reversal / Enrollment Requests.

The student can check the insurance website for an explanation of plan benefits and to find out how to access the insurance ID number via the app. Please contact our office with any questions at the email address above.

Instructions: Please complete all sections, sign, date, and submit to the Student Health Insurance Department

Last Name	First Name	MI	Student ID	DOB
Local Address		City	State	Zip
Telephone Number			Email	
Reason for request:				
Specify Term (Check only one of the boxes)				
<input type="checkbox"/> Fall <input type="checkbox"/> Winter <input type="checkbox"/> Spring <input type="checkbox"/> Summer				
Undergraduate UC SHIP <input type="checkbox"/>	<input type="checkbox"/> I wish to reverse the UC SHIP Health Insurance Waiver that was previously submitted. <input type="checkbox"/> I wish to enroll in the UC SHIP Health Insurance. I wish to accept the University Insurance and will pay the per quarter fee for Undergraduate UC SHIP beginning with the term specified above.			
Graduate UC SHIP <input type="checkbox"/>	<input type="checkbox"/> I wish to reverse the UC SHIP Health Insurance Waiver that was previously submitted. <input type="checkbox"/> I wish to enroll in the UC SHIP Health Insurance. I wish to accept the University Insurance and will pay the per quarter fee for Graduate UC SHIP beginning with the term specified above.			
Student Signature (Parent/Guardian signature if student is a minor)			Date	

For Office Use Only

Reviewed by:	Date approved:	FM Ins Tab Updated:		FM CC Tab Updated:		PnC Updated:		AIS Updated:		AHP Spreadsheet updated:		AHP Waiver site updated:	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No