

UC SHIP WAIVER REQUEST FORM WORKSHEET
2020-21 Academic Year
STUDENT HEALTH INSURANCE PLAN (SHIP) WAIVER WORKSHEET
2020-21 Academic Year

IMPORTANT POP-UP Alert:

Disable your POP-UP Blocker when you enter the online Waiver Form to receive important pop-up options.

DEAR STUDENT: Complete the waiver form easily and quickly by preparing your answers ahead of time. This worksheet can help you gather needed insurance information BEFORE you start the online Waiver Form. You may not be required to answer all these questions, depending on your health plan type.

Have your health plan booklet, benefits summary, or contract/policy handy to answer the questions listed below. Call the customer service number listed on your insurance card; or check online health plan information to find the details of your plan if you have questions.

NOTE: Insurance terminology in bold italics is defined in the GLOSSARY of Medical Insurance Terminology.

THE SHIP WAIVER FORM WILL REQUEST THE FOLLOWING INFORMATION	ANSWERS FROM PLAN BOOKLET, SUMMARY OF BENEFITS, OR CONTRACT/POLICY	NOTES
YOUR HEALTH INSURANCE PLAN		
Select one of the following to describe your health insurance plan: Covered California Plan; Medicare; Medi-Cal; Military/TRICARE; University of California employee plan, ministry sharing plan, or another Employer Group Health Insurance Plan ? (Select "Other" if your plan is not one of these.)		
If you have Medi-Cal (California Medicaid), which county is your Medi-Cal from?		
Please indicate the type of health insurance plan you have:	HMO (Health Maintenance Organization) EPO (Exclusive Provider Organization) PPO (preferred provider organization) POS (Point-of-Service) Other/I don't know	
PERSONAL AND HEALTH PLAN INFORMATION		
Provide your name, student ID number issued by your campus, current address, email address and phone number.		
Provide the name, address and phone number of your health insurance plan. You will also be asked to provide your insurance plan member subscriber identification number, or your medical record number, if you have Kaiser. This information is printed on your insurance ID card. The Waiver Form will have a drop-down menu with a list of insurance companies from which to select. If you select "Other," you will be asked to provide the name, address and phone number of your health insurance company. You will need to provide a copy of the front and back of your ID card, a copy of your benefit summary and/or a copy of your policy.		
What is the name of the Primary Enrollee or Subscriber on your health plan?		

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Please let us know your main reason for choosing to waive SHIP.

I am on my parent's plan; I am on my spouses/domestic partner's plan; financial aid doesn't pay for SHIP; I found another plan that costs less; my plan has no copays (e.g. Medi-Cal); my plan has richer benefits than SHIP in the USA; other

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QUESTIONS ABOUT YOUR HEALTH PLAN BENEFITS		
Does your health insurance plan provide unrestricted access to an in-network primary care provider and hospital providing full, non-emergency medical and behavioral health care within 30 miles of campus while attending school?	(YES or NO)	
Does your health insurance plan have unlimited annual and lifetime in-network benefits?	(YES or NO)	
Does your health insurance plan cover inpatient and outpatient hospital services for medical and surgical care?	(YES or NO)	
Does your health insurance plan cover hospital stays for mental health care and substance abuse disorder conditions the same as any other medical condition?	(YES or NO)	
Does your health insurance plan cover office visits for medical, including mental health and substance abuse conditions?	(YES or NO)	
Does your health insurance plan provide coverage for all Minimum Essential Health Benefits. For the criteria, please see: https://www.cms.gov/cciio/resources/data-resources/ehb.html	(YES or NO)	
Is your health 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 your home government or from another party.	(YES or NO)	
If your Annual Out-of-Pocket Maximum limit is more than \$8,150 (or more than \$16,300 for a family), do you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) funded sufficiently to reduce the total out-of-pocket expenses to \$8,150 for an individual, or \$16,300 for a family, or less?	a) individual plan - up to \$8,150 or less; b) individual plan - over \$8,150; c) individual plan - over \$8,150 with a Health Savings or Health Reimbursement plan; d) family plan - up to \$8,150 per individual family member or \$16,300 for the family; e) family plan - over \$16,300; f) family plan - over \$8,150 per member with a health care or health reimbursement plan	
International Students: Does your health insurance company have a complete master policy written in Standard English with benefits expressed in U.S. dollars?	(YES or NO)	
Does your medical insurance plan have a claims payment office with an address and phone number in the United States?	(YES or NO)	
International Students: Does your health insurance plan have a maximum benefit limit per-medical or per mental health/substance use disorder-condition per year?	(YES or NO)	
International Students: Does your health plan cover services related to suicidal conditions, including attempted suicide or suicidal thoughts?	(YES or NO)	
International Students: Does your health insurance plan have a Pre-existing Condition Exclusion or waiting period (or limitation) ?	(YES or NO)	
International Students: If you answered YES to the preceding question, have you been on your health plan long enough so that you are no longer subject to your plan's pre-existing condition limitation or waiting period?	(YES or NO)	
International Students: Does your health plan cover medical services (inpatient or outpatient) for illness or injury resulting from participation in recreational activities or amateur sports?	(YES or NO)	
International Students: Does your plan cover at least \$50,000 for a Medical Evacuation ?*	(YES or NO)	

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International Students: Does your plan cover at least \$25,000 for Repatriation of Remains ?*	(YES or NO)	
<i>NOTE: The Exclusions and Limitations section(s) in your health plan booklet or contract/policy may contain information requested in the questions below.</i>		