*INTERNAL OFFICE USE ONLY*

| ☐ Mail | ☐ Email | ☐ Walk-In | ☐ Fax | DATE RCVD: |
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# UC SHIP DENIED WAIVER APPEAL FORM
## Academic Year 2014-15

***DEAR STUDENT:*** Please complete this form with valid and current information regarding yourself and your private health insurance plan. Your plan must meet the current academic year's waiver criteria. If your plan fails by a single criterion, you are not permitted to waive enrollment in UC SHIP. Please consult with your plan representative if you need assistance.

## PART I. STUDENT INFORMATION

**Name (Last, First)** **Student ID#**

**Current Address (City, State, and Zip Code)** **Best Phone #**

**Email Address**

**Check current term of appeal:**

- ☐ Fall 2014/Academic Year 2014-15
- ☐ Winter Quarter 2015
- ☐ Spring Quarter 2015
- ☐ Spring Semester 2015

**Student Status**

- ☐ Undergraduate
- ☐ Graduate – Semester
- ☐ Graduate – Quarter
- ☐ Anderson – FEMBA

## PART II. PROOF OF PRIVATE INSURANCE COVERAGE (PLEASE ATTACH DOCUMENTS.)

***It is necessary that we have a complete survey of your health insurance plan benefits to determine if it meets the UC SHIP Waiver Criteria. Please provide the following requested documents. It may be helpful to seek assistance from your benefits summary, booklet, contract, or policy, or ask your insurance company representative.***

- A copy of the front and back of your valid insurance identification card
- Proof of insurance dependency IF you are not self-insured but are under a parent's plan (proof may be a printout from your online insurance account listing the subscriber and their following dependents, naming the student as one of them, OR if the insurance identification card already states so)
- A benefits summary, booklet, contract, or policy giving details for medical, mental health and substance, and pharmacy benefits. A benefits summary usually looks like a table chart or matrix that organizes the breakdown of how your plan will pay for inpatient and outpatient benefits expressed in dollars and/or percentages.

## PART III. TERMS AND CONDITIONS

**By initialing in the fields below and signing at the bottom of this page, I acknowledge the following:**

____ I am requesting to waive the UC Student Health Insurance Plan (UC SHIP) by this appeal process. I certify that the information I have provided is valid and accurate. I understand that if this information is found to be invalid, inaccurate, or does not meet the criteria for waiving out of UC SHIP, I will be enrolled in UC SHIP and the appropriate fee(s) will be billed to my student account.

____ I agree to provide a copy of my health insurance identification card supporting documentation as requested by the University or its agent. I understand that if I fail to submit my appeal and/or provide documentation upon request within the designated 14 days, I will be enrolled in UC SHIP and the appropriate fee(s) for the full coverage period will be billed to my student account.

____ I agree and understand that I am obligated to follow through with upon hearing the result of my appeal. This means that should my UC SHIP waiver remains denied, I will be enrolled in UC SHIP and the appropriate fee(s) for the full coverage period will be billed to my student account. Additionally, I understand that once the result of my appeal is determined, there is no secondary appeal process.

**Please note that it may take up to 30 business days to review your appeal. The result will be emailed to you by an insurance specialist or assistant. Please make sure that your email address above is valid and functional.**

**Student's Signature:** _____ **Date:** _____

If a parent or legal guardian is completing this form for the student, please state your full name and relationship to the student.

**Name:** _____

**Signature:** _____ **Date:** _____

## PART IV. SUBMISSION OPTIONS

**You may choose either of the following options to submit your appeal.**

Mail: UCLA Arthur Ashe Center
Student Health Insurance Office
221 Westwood Plaza, Room #412
Los Angeles, CA 90095

Please note that mailing may cause a delay on the receipt of your appeal. Mailing days will be accounted for within the 14-day grace period. Please take this into serious consideration.

Fax: 1-(310)-206-1651

Faxes must be clear and legible. **DO NOT FAX DURING HOLIDAY BREAKS**

Email: SHSINS@ashe.ucla.edu

Please ATTN: Waiver Denial Appeal for Student's Name. Scanned documentations must be clear and legible.

Walk-In: UCLA Arthur Ashe Center, Adjacent to the John Wooden Center
4th Floor at the Insurance Window, Hours: M-T 8am-5pm, F 9am-5pm