**UC SHIP DENIED WAIVER APPEAL FORM**  
Academic Year 2015-16

**DEAR STUDENT:** Please complete this form with valid and current information regarding yourself and your private health insurance plan. **This application must be completed in its entirety for consideration.** 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**

<table>
<thead>
<tr>
<th>Name (Last, First)</th>
<th>Student ID#</th>
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<tr>
<th>Current Address (City, State, and Zip Code)</th>
<th>Best Phone #</th>
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<tr>
<th>Student Email Address</th>
<th>Parent/Guardian Email Address</th>
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**Note:** Appeals will be considered for the current term ONLY. Waivers granted on appeal will NOT be applied to any previous term.

**Check current term of appeal:**

<table>
<thead>
<tr>
<th>Fall Quarter/Semester 2015/Academic Year 2015-16</th>
<th>Winter Quarter 2016</th>
<th>Spring Quarter 2016</th>
<th>Spring Semester 2016</th>
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<tbody>
<tr>
<td>Student Status:</td>
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<tr>
<td>Undergraduate</td>
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<tr>
<td>Graduate - Semester (Law/Medicine)</td>
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<td>Graduate - Quarter</td>
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<tr>
<td>Anderson - FEMBA</td>
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**PART II. PROOF OF PRIVATE INSURANCE COVERAGE (PLEASE ATTACH REQUESTED)**

> A copy of the front and back of your valid insurance identification card.

Please check off one of the following:

- Individual / Family Plan
- Employer / Group Plan (If checked, please provide the following information requested below)
  - Employer Company Name: ____________________________
  - Company Address: _________________________________
  - Company Phone #: _____________________________

**IMPORTANT:** Please provide a copy of your plan’s **benefits summary, booklet, contract, or policy** that details 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.

*Correspondences will be handled via email to the student’s email address. If you are a parent submitting this on behalf of your student and would like to know the status of this appeal request, please provide your email address above alongside the student’s email address.*

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*Please note: Minimum benefit standards represented for the 2015-16 academic waiver may be revised for further waiver periods if healthcare legislation requires such a change.*

Updated 080415
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 (fourteen) 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. You are still responsible for making sure that your tuition and registration fees are paid by your fee payment deadline. If your request is approved after you have paid your fees, your student account will be credited and you will be reimbursed the premium fee for the current term.

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: ___________________________ Relationship: ___________________________

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: UCShipWaivers@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

Please note: Minimum benefit standards represented for the 2015-16 academic waiver may be revised for further waiver periods if healthcare legislation requires such a change.

Updated 080415