UCLA Student Health & Counseling

Academic Year 2026-2027

Health Fee Waiver Appeal Review Request Form

Use this form to request a review of Academic HealthPlans (AHP) decision to deny your health fee waiver application.

Please read the following instructions before completing this form:

1. **Eligibility -** Requests will be reviewed for the current academic term only**.** Applications submitted for past terms will not be considered.
2. **Submission Deadline -** Requests must be submitted via email to ucshipwaivers@ashe.ucla.edu no later than 5:00 PM (PDT) on the applicable term's appeal deadline.

Term	Quarter Program	Appeal Deadline
Summer	SP, FSP, TSP MBA (1st Year)	08/14/26
	MSAUD (1st Year)	08/21/26
Fall	FEMBA (1st Year)	09/11/26
	Undergraduate* Graduate**	10/09/26
Winter	All Quarter Programs	01/15/27
Spring	All Quarter Programs	04/09/27

*Includes Summer Pathways (SP), Transfer Summer Program (TSP), Freshmen Summer Program (FSP)
**Includes all UC SHIP Participating Self-Supporting Programs (SPP)

Term	Semester Programs	Appeal Deadline
Summer	MED – 2nd, 3rd, & 4th Year	07/03/26
Fall	LAW – LLM & IEP	08/28/26
	LAW - MLS (1st Year)	08/21/26
	LAW - JD (1st Year)	09/04/26
	LAW - JD (2L & 3L), MLS, & SJD	09/11/26
	MED – 1st Year	08/28/26
	MED – 2nd, 3rd, & 4th Year	09/04/26
Spring	LAW - JD (1st Year)	01/29/27
	All other Semester Programs	01/15/27

Student Information		
Last Name	First Name	University ID (UID)
Term	☐ Summer ☐ Fall ☐ Winter ☐ Spring	

Check One Statement:

☐ I am submitting additional documentation demonstrating that my health plan meets university requirements.

☐ I am an In Absentia graduate student. Attached is my signed In Absentia Registration Petition form or written confirmation of my approved In Absentia status.

☐ I am a remote, commuter, or hybrid student whose primary residence is more than 75 miles from the UCLA campus.

Student Agreement

1. I confirm that the information provided is accurate. I understand that if it is found to be incorrect or does not meet waiver requirements, I will be financially responsible for the health fee.
2. I understand that my health plan must meet all university requirements, including having a primary care provider (PCP) or medical group assignment and a coverage start date on or before the start of my program term.
3. I understand that if the Insurance Services Office at the Ashe Center agrees with Academic Health Plans (AHP) that my plan does not meet university requirements, I will remain enrolled in UC SHIP for the term, be responsible for the health fee, and will not be able to submit any further appeals for that term.
4. I understand that it is my responsibility to follow up with the Insurance Services at The Ashe Center regarding the status of my submission.

Student Signature	Date (MM/DD/YYYY)