UNIVERSITY HEALTH SERVICES *Tang Center*
People. Campus. Community.

UNIVERSITY OF CALIFORNIA, BERKELEY

STUDENT HEALTH INSURANCE PLAN (SHIP)
WAIVER REVERSAL REQUEST FORM
FALL 2009

As a UC Berkeley registered student, you must enroll in SHIP *if*

1. You are no longer covered by the health insurance plan named on the waiver application you submitted for this academic year *OR*
2. Your insurance does not meet minimum requirements for a waiver of SHIP.

In order to reverse the decision to waive the Health Insurance Fee, and enroll in the Student Health Insurance Plan for the Fall 2009 Semester, please:

1. Obtain verification from your former insurance company stating the date your coverage ended and attach it to this form. If you were subsequently enrolled in a different plan that does not meet the minimum requirements for waiving SHIP, attach a summary of the benefits for that plan. NOTE: Between July 15 and August 14 2009, this information is NOT required to enroll in SHIP for Fall 2009.
2. Complete this form. Keep a copy of the completed form as your receipt.
3. Mail or bring this form to: ***Student Health Insurance Office***
   Tang Center, UC Berkeley
   2222 Bancroft Way, Rm. 3200
   Berkeley CA 94720-4302

If you enroll after the first day of the current coverage period, your coverage will begin the day this application is accepted by the Student Health Insurance Office.

SID Number from UCB Photo ID	❑ Undergraduate ❑ Graduate ❑ International Student	*Social Security Number*	
Last Name	*First Name*	*Date of Birth*	❑ *Male* ❑ *Female*
Address *City* *State* *Zip Code*		*Telephone Number*	

Reason for Waiver Reversal Request (Please choose one of the following):

❑ Comparable insurance coverage is no longer available (e.g., loss of employment or change in benefits)
❑ Student's age exceeds maximum allowed by parent's policy
❑ Other. Please explain: ______________________________

Today's Date:	*Date Coverage Expires:*

I understand and agree that if I am granted a waiver reversal, my Student Health Insurance Plan coverage will begin either on the first day of the current policy period (January 15 for Spring Semester and August 15 for Fall Semester) *or* on the date my application is accepted by the Student Health Insurance Office. I further understand that the fee assessed to me will be the full amount for the applicable policy period.

Applicant's Signature	*Date*
______________________________	______________

Staff Initials:	**Coverage Begins on:**	**Enrolled Student Y ____ N ____**	**OR Updated**	**Database Updated**