



**STUDENT HEALTH INSURANCE PLAN (SHIP)
WAIVER REVERSAL REQUEST FORM
SPRING 2012**

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 Spring 2012 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 December 1, 2011 and February 1, 2012, this information is NOT required to enroll in SHIP for Spring 2012.
2. Complete this form. Keep a copy of the completed form as your receipt.
3. Mail, fax or bring this form to: **Student Health Insurance Office
3200 Tang Center
2222 Bancroft Way
Berkeley CA 94720-4300
Fax: 510-642-9119**

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.

<i>SID Number from UCB Photo ID</i>	<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate	<i>SSN (Last 4 Digits)</i>	
<i>Last Name</i>	<i>First Name</i>	<i>Date of Birth</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i> <i>Telephone Number</i>
<p>Reason for Waiver Reversal Request (Please choose one of the following):</p> <input type="checkbox"/> Comparable insurance coverage is no longer available (e.g., loss of employment or change in benefits) <input type="checkbox"/> Student's age exceeds maximum allowed by parent's policy <input type="checkbox"/> Other. Please explain: _____			
<i>Today's Date:</i>		<i>Date Coverage Expires:</i>	

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.

<i>Applicant's Signature</i> _____	<i>Date</i> _____
---------------------------------------	----------------------

Staff Initials:	Coverage Begins on:	Enrolled Student Y ___ N ___	OR Updated	Database Updated
------------------------	----------------------------	--	-------------------	-------------------------