



WAIVER REVERSAL FORM

Return Completed Form To:

Student Health Insurance Office

501 Student Health

Irvine, CA 92697-5200

FAX: (949) 824-5062

Securely Upload in the Patient Portal

*Emailed forms will NOT be processed.

WAIVER REVERSAL REQUEST ACADEMIC YEAR 2023-2024

Student ID Number		UCI Email		Telephone Number	
Last Name		First Name		Middle Initial	
Address		City	State	Zip Code	Date of Birth
Reason for Waiver Reversal Request (Please choose one of the following): <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: _____					
Specify term you wish to enroll: <div>Fall 2023 <input type="checkbox"/> Winter 2024 <input type="checkbox"/> Spring/Summer 2024 <input type="checkbox"/></div>					

I wish to reverse the University Student Health Insurance Plan (SHIP) Waiver that was previously submitted. I wish to accept the University SHIP and will pay the per quarter/semester fee charged to my student account beginning with the term specified above. I understand and agree that if I am granted a waiver reversal, my SHIP coverage will begin either on the first day of the current policy period or on the date my previous coverage ends. Subject to approval by the Student Health Insurance department.

<i>Applicant's Signature</i>	<i>Date</i>
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For Office Use Only

Date Received	Reviewed By	SBS Updated()	AHP Updated()
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