UCI Student Health Center

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 2024-2025

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):

- ☐ 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: _____

Specify term you wish to enroll:

Fall 2024 ☐ Winter 2025 ☐ Spring/Summer2025 ☐

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.

Applicant's Signature	*Date*

For Office Use Only

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