

STUDENT HEALTH INSURANCE PLAN (SHIP)

APPEAL OF WAIVER DENIAL

INSTRUCTIONS: Please read this material below before filing an Appeal:

1. If your Waiver Application was denied because you missed the waiver application deadline, **DO NOT FILE AN APPEAL**. Appeals will not be considered for students missing the waiver deadline.
2. **Your appeal must be submitted within five (5) days of the date of notice of denial.** Appeals received after the five day grace period will not be considered. **Enclose a copy of the Waiver Application Denial.**
3. Appeals will be considered for the current term only. Waivers granted on appeal will **NOT** be applied to any previous school term.
4. Evaluation of your appeal will be based on comparability insurance guidelines in effect at the time of the original waiver application.

SECTION A: Student Information (please print legibly) Undergraduate Graduate

Last Name	First Name	MI	Student ID	DOB
Current Address	City	State	Zip Code	Telephone Number
UC Merced Email Address (If you do not have UC Merced email address, you may enter an alternative email address for this mailing only)				

Term of Appeal: Academic Year 2006-2007 Fall Term 2006 Spring Term 2007

In the space provided below (and on back of this form, if necessary) state the nature of your request and circumstances of your case. Please be detailed and specific. Type or write legibly.

Attach any supporting documentation for your appeal. Include a copy of your plan benefits.

Return to: Health Services & Insurance Administrator
Student Health Center
University of California, Merced
5200 North Lake Road
Merced, CA 95340

Dear Insurance Administrator:

I attest that the above information is true and accurate to the best of my ability.

APPLICANT'S SIGNATURE _____ DATE _____

Office Use Only:

Waiver Appeal Approved Not Approved Initial _____ Transaction # _____

Reason _____