

STUDENT HEALTH INSURANCE PLAN (SHIP)

REQUEST TO CANCEL WAIVER

A SHIP ENROLLMENT APPLICATION (page 2) must accompany a REQUEST TO CANCEL WAIVER.

Student Information (please print legibly) Undergraduate Graduate

Last Name	First Name	MI	Student ID	DOB
Current Local 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)				

I am requesting a cancellation of my waiver to the UC Merced Student Health Insurance Plan (SHIP). I understand the cancellation will remain in effect until another waiver application is submitted.

The cancellation will be effective the date this request is received, or a future date specified here:

Effective Starting _____ Semester 20 _____
Year

I understand that SHIP coverage for semesters in progress will start on the effective date specified on this waiver cancellation request. I will be responsible for a full semester SHIP fee, as SHIP fees are not prorated. The SHIP fee will be billed to my student account.

APPLICANT'S SIGNATURE _____ DATE _____

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

Office use only:

_____ Date Cancelled

_____ Effective Date

Graduate Student

Undergraduate Student

_____ Initials

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SHIP ENROLLMENT APPLICATION

STUDENT HEALTH INSURANCE PLAN (SHIP)

SHIP ENROLLMENT APPLICATION

A SHIP ENROLLMENT APPLICATION must accompany a REQUEST TO CANCEL WAIVER (page 1).

All UC Merced registered students are automatically enrolled in the Student Health Insurance Plan (SHIP) and are not required to submit an enrollment application. This form is intended for students canceling their SHIP Waiver.

Student Information (please print legibly)				<input type="checkbox"/> Undergraduate	<input type="checkbox"/> Graduate
Last Name	First Name	MI	Student ID	DOB	
Current Local 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)				<input type="checkbox"/> Male	<input type="checkbox"/> Female

Coverage Information

Please indicate your requested Semesters of coverage (*must be contiguous*)

Fall 2006 Spring 2007 Summer 2007

Effective Date of Coverage: Your coverage will begin on the first day of the semester indicated above. However, if you are enrolling for the current semester already in progress, your coverage will begin on the date your application is received in the Student Health Center.

SHIP Enrollment Costs	Fall 2006 8/20/2006 – 01/05/2007	Spring 2007 01/05/2007 – 08/20/2007	Summer 2007 05/20/2007 – 08/20/2007
Undergraduate Students	\$316	\$427	TBA
Graduate Students	\$538	\$732	TBA

Your Student Account will be billed.

Amount Due \$ _____

Signature _____ Date _____

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Student Health Center
University of California, Merced
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Merced, CA 95340