UCDAVIS HEALTH | SCHOOL OF MEDICINE
Registrar's Office

4610 X Street, Suite 1208, Sacramento, CA 95817
Tel: 916-734-4027 | Fax: 916-734-2178
hs-studentrecords@ucdavis.edu

Insurance Waiver Form (MD Students Only)

Your insurance enrollment and fee will NOT be waived if you fail to follow all instructions below:

1. Complete all required sections on this form.
2. Attach a letter from your insurance company dated within the last 30 days, stating you have insurance coverage. The letter must have your name and the effective date of your coverage. **Insurance cards alone are NOT accepted for this requirement.**

For detailed insurance information please visit: https://health.ucdavis.edu/mdprogram/registrar/insurance.html

SECTION 1: MEDICAL STUDENT INFORMATION - REQUIRED

Last name	First name	MI

Student ID	Date of Birth (MM/DD/YYYY) / /
Current Class Level ☐MS1 ☐MS2 ☐MS3 ☐MS4 ☐other	Phone no, ( )

I am in a dual degree program: ☐Y ☐N

1) I currently receive insurance coverage through (select ONE):

☐My parents (I am younger than age 26) ☐Spouse/legal partner ☐Other private insurance

2) I am requesting to waive out of SOM-sponsored health coverage for the following quarters:

☐**Summer**	☐**Fall**	☐**Winter**	☐**Spring**	**Academic Years:**
July, August, September	October, November, December	January, February, March	April, May, June	20____ through 20 ____ (Example: 2021 through 2024)

SECTION 2: HEALTH INSURANCE INFORMATION - REQUIRED

If you are waiving out of the SOM-sponsored insurance, you are required to have health services within **50 miles** of Sacramento. If not within **50 miles**, your waiver request will be denied, and you will remain enrolled in the SOM-sponsored insurance plan. All applicable fees will be charged to your student account.

1) Are primary care services available to you within 50 miles of Sacramento? *Verify distance with a Web-based map service.*

☐Yes ☐No

I receive primary care services at: _____
Address/Facility

2) Is a covered emergency care provider available to you within 30 miles of Sacramento?

☐Yes ☐No

Attach a letter from your insurance provider dated within the last 30 days, stating you have insurance coverage.

SECTION 3: SIGNED WAIVER AGREEMENT - REQUIRED

I certify that the information provided above is accurate. I understand that if this information is found to be inaccurate, invalid, or does not meet the criteria for waiving out of health insurance, I will be enrolled in the SOM-sponsored insurance plan and the fees will be billed to my student account. **I agree that I will maintain comparable health insurance at all times during this waiver period**. If my health insurance coverage is terminated, I will immediately notify the Office of Medical Education, School of Medicine, Registrar's Office.

Student Signature: _____ Date: _____

Office Use Only ☐ Approved ☐ Denied Reason for approval or denial: _____

Effective quarter: _____ Effective month: _____ ☐ Excel: _____ ☐ WHA site: _____

☐ Premier site: _____ ☐ VSP site: _____ ☐ TSAAREV: _____ ☐ Depend. TSAAREV: _____

☐ Excel: _____ ☐ Billing Doc: _____ ☐ MyRecordTracker: _____ ☐ Dep. in WHA/Premier/VSP: _____

☐ TSAEXPP/Banner Waiver added/removed: _____ ☐ Notify Financial Aid: _____