UC DAVIS HEALTH | SCHOOL OF MEDICINE

Insurance Waiver Form for UC Davis Medical Students

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

1. COMPLETE sections A, B, and C.
2. Provide a copy of your health insurance card or other proof of insurance along with this application.
3. Waiver can be submitted by mail, email or fax.
   Office of Medical Education 4610 X Street Suite 1208 Sacramento CA 95817
   Hs-studentrecords@ucdavis.edu
   (916) 734-2178

Waiver applications must be filed annually (in June). Your approved waiver will be effective for the duration of one year. Questions about health/dental/vision coverage, waiver guidelines, and the waiver process should be directed by e-mail to: hs-studentrecords@ucdavis.edu

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

Section A: Medical Student Information

Year in School (Circle one) 1 2 3 4		I am in a dual degree program Y N	
LAST NAME	FIRST NAME MI	STUDENT IDENTIFICATION #	DATE OF BIRTH
CURRENT ADDRESS	CITY STATE ZIP		TELEPHONE NUMBER
I currently receive insurance coverage by the following means (please select **ONE** of the following): ☐ Through my parents (Younger than age 26) ☐ Through my spouse/legal partner ☐ Through privately paid insurance (out of pocket)			
During medical school, I plan to waive out of health coverage the following Quarters (Please select all that apply): ☐ Summer Quarter Fall Quarter _____ Winter Quarter _____ Spring Quarter _____ Academic Year_____			

Section B: Health Insurance Information

INSURANCE COMPANY NAME	MEMBER ID NUMBER
1. Is your insurance plan owned, headquartered and operated in the United States?	*Circle one:* YES NO
2. Primary care services are available to you within 90 miles of Sacramento? My medical insurance covers primary care services I receive at _____ (enter an address within 90 miles of the UC Davis School of Medicine)	*Circle one:* YES NO
3. Is a covered emergency care provider available to you within 30 miles of Sacramento?	*Circle one:* YES NO
You will ONLY need to answer to questions 4, 5 and 6 if your health plan is PPO (not HMO). THE PLAN MUST MEET AT LEAST TWO OF THESE THREE FOLLOWING CRITERIA:	
4. According to your insurance policy, what is your maximum annual out-of-pocket expense (including deductible)? Not to exceed $5,000	$
5. What is your insurance plan's maximum lifetime benefit? At least $400,000	$
6. What is your insurance plan's reimbursement rate for covered medical services (this is usually expressed as a percentage, e.g., plan pays 80%, you pay 20%)? At least 80%	%

Section C: Notification Signed Waiver Agreement

I certify that the information I have 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 health insurance and the fee 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.

Date: _____ Applicant's Signature: _____