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 fee will NOT be waived if you fail to follow all instructions below:

1. COMPLETE sections A, B, and C. Incomplete waiver forms will not be processed.
2. Provide 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.
3. Waiver forms must be filed annually. Your approved waiver will be effective for one year, unless your insurance letter indicates an earlier date of expiration.

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

SECTION 1: MEDICAL STUDENT INFORMATION

Current Class Level: ☐ MS1 ☐ MS2 ☐ MS3 ☐ MS4 ☐ other I am in a dual degree program: ☐ Y ☐ N

Name: _____ / _____ / _____ Date of Birth: _____
Last First MI

Student ID Number: _____ Phone #: _____-_____-_____

Q1: I currently receive insurance coverage through (select ONE):

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

Q2: I plan to waive out of SOM-sponsored health coverage for the following quarters:

☐ **Summer**	☐ **Fall**	☐ **Winter**	☐ **Spring**	**Academic Year:**
July, August, September	October, November, December	January, February, March	April, May, June	_____

SECTION 2: HEALTH INSURANCE INFORMATION

If you are waiving out of the SOM-sponsored insurance, you are required to have health services within 50 miles of Sacramento.

Insurance company name: _____

1. Are primary care services available to you within 50 miles of Sacramento? ☐ 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

SECTION 3: SIGNED WAIVER AGREEMENT

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 must enroll 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

Effective quarter: _____ Effective month: _____ Excel: _____
WHA: _____ Premier: _____ VSP: _____
TSAEXPP: _____ TSAAREV: _____ Notify Financial Aid: _____
Dependents in TSAAREV: _____ Dep. in WHA/Premier/VSP: _____ HSSIS: _____