University of California, Davis
School of Medicine, Registrar's Office

4610 X Street, Suite 1208, Sacramento CA 95817-2200 / Phone: (916) 734-4027 / Fax: (916) 734-2178

Insurance Waiver Form

INSURANCE WAIVER FORM FOR UC DAVIS MEDICAL STUDENTS

READ THESE INSTRUCTIONS. ***Your insurance fee will NOT be waived if you fail to follow all of the instructions listed below***:

1. **COMPLETE** sections A, B, and C. **(*Incomplete applications will be returned without approval.)***
2. **MAKE A COPY** of this application and retain it as your receipt. **SUBMIT** the completed waiver application to:
   School of Medicine Registrar's Office
   Medical Education Building
   4610 X Street, Suite 1208
   Sacramento, CA 95817
   Fax: (916) 734-2178
3. Waiver applications **must be filed annually (in June)**. Your approved waiver will be effective for the duration of one year.
4. Questions about health/dental/vision coverage, waiver guidelines, and the waiver process should be directed by e-mail to hs-studentrecords@ucdavis.edu or by phone to 916-734-4027.

All applicants are required to provide a copy of their health insurance card or other proof of insurance along with this application.

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 NUMBER	DATE OF BIRTH
CURRENT ADDRESS / CITY / STATE / ZIP CODE			TELEPHONE NUMBER

I currently receive insurance coverage by the following means (please select ONE of the following):
☐ Through my parents (I am younger than age 26) ☐ Through my spouse/legal partner ☐ Through privately paid insurance (out of pocket coverage)

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. Please provide the following information about your health insurance:

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 50 miles** of Sacramento? My medical insurance covers primary care services I receive at _____ (enter an address **within 50 miles** of the UCD SOM)	*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_____

FOR OFFICE USE ONLY:	APPROVED_____	DENIED_____	BY:_____	DATE_____	
	SUMMER QUARTER___	FALL QUARTER___	WINTER QUARTER___	SPRING QUARTER___	