

**STUDENT HEALTH INSURANCE PLAN (SHIP)
APPLICATION FOR HEALTH INSURANCE FEE WAIVER FOR THE 2006-2007 ACADEMIC YEAR**

Instructions:

- 1) If you have your own insurance and wish to waive out of the Mills SHIP, please complete all information requested below and sign at the bottom of the form.
- 2) This form must be submitted or postmarked by **August 1, 2006** to avoid a late fee. Forms submitted or postmarked between August 2 and August 30 will be subject to a \$150 Late Major Medical Waiver Fee.
- 3) Mail, fax or bring this completed waiver form to Mills College, M Center, 5000 MacArthur Blvd., Oakland, CA 94613; Fax: 510.430.2003.
- 4) Check your student account via myMILLS to verify that your account has been credited. The burden of proof that a waiver form was received and credited is placed on the student.
- 5) This waiver is effective for the 2006-2007 academic year only. A new waiver form must be submitted each year.
- 6) More information about the Mills SHIP can be found online: http://www.mills.edu/student_services/health_and_counseling/health.php.

No waiver forms will be accepted after August 30 – no exceptions – and the insurance fee cannot be petitioned. Waiver forms submitted by the stated deadline will be credited on or before the September billing statement. If you miss the submission deadline, the major medical insurance fee will not be waived for the fall semester and you will be enrolled in the plan. In this case, you are encouraged to submit a waiver for the spring semester.

Student Information				
Please check the appropriate box that indicates your current registration status:				
<input type="checkbox"/> Undergraduate	<input type="checkbox"/> Full-time Graduate	<input type="checkbox"/> Part-time Graduate	<input type="checkbox"/> International Student	<input type="checkbox"/> Exchange Student
Mills ID: _____	Date of Birth: _____	Email Address: _____		
Name: _____	Telephone Number: _____			
Last	First	M.I.		
Address: _____				
Street Address	Apt. No.	City	State	Zip Code

Health Insurance Information	
Insurance Company Name: _____	Insurance Company Phone Number: _____
Policy Holder's Name: _____	Policy Holder's Identification Number: _____
Policy Holder's Relationship to You: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	
This plan is a(n): <input type="checkbox"/> Group Plan (provided by an employer or other plan sponsor) <input type="checkbox"/> Individual Plan (purchased by the policy holder)	

Members of Kaiser, Medi-Cal and Military insurance plans do not need to complete Health Insurance Plan Benefit Information below.

Type of Benefit	Your Plan's Benefits	Minimum Benefits Required to Waive SHIP
Maximum lifetime benefit	\$ _____	\$250,000.00
Inpatient Mental Health Services	_____ days	15 days
Annual deductible	\$ _____	\$500.00 or less
Hospitalization/Professional fees	_____ %	100 % / 80 %
World Wide Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Authorized Out of Area Care

I understand that I am waiving major medical, dental care, and mental health insurance benefits and certify that the above information is accurate. I further understand that waiver information is audited and if the information I provided is found to be invalid, I will be enrolled in SHIP automatically and will be responsible for paying the cost of the plan. I understand and agree that if I am granted a waiver, **I will maintain comparable health insurance at all times during this waiver period. I understand and agree that if my health insurance coverage is terminated, I will submit a Major Medical Waiver Reversal Request form to the M Center at Mills College within 30 days.** I further understand that neither UHS nor Mills College is responsible for payment of my medical bills.

Applicant's Signature: _____

Date: _____