



**STUDENT HEALTH INSURANCE OFFICE**

3200 Tang Center • 2222 Bancroft Way, Berkeley, CA 94720-4300

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**FALL SEMESTER 2009**

**STUDENT HEALTH INSURANCE PLAN  
ENROLLMENT APPLICATION**

FOR GRADUATE STUDENTS ON APPROVED LEAVE OR FILING FEE STATUS  
AND UNDERGRADUATE UC EXTENSION CONCURRENT ENROLLMENT STUDENTS

**Instructions:**

1. Complete this application form.
2. Provide required documentation:
  - a. **Filing fee/withdrawal status graduate students:** Provide EITHER a copy of your approved notice of withdrawal or filing fee application OR a memo from your department stating that you are currently a student in good standing on approved leave or filing fee status for this semester.
  - b. **Concurrent enrollment undergraduate students:** Provide a memo from your department stating that you are currently a student in good standing fulfilling graduation requirements, AND proof of payment of UC Extension fees.
3. Make your check for **\$1,760** payable to **UC Regents**.
4. Bring or mail this completed form, copy of your application or departmental memo, and check for the fee to the Student Health Insurance Office.

- **SHIP COVERAGE FOR FILING FEE AND APPROVED LEAVE STUDENTS IS AVAILABLE FOR A MAXIMUM OF TWO SEMESTERS.**
- **SHIP COVERAGE FOR CONCURRENT ENROLLMENT STUDENTS IS AVAILABLE FOR ONE SEMESTER ONLY.**

**Application Deadline for Continuous Coverage: September 15, 2009**

Applications submitted during the enrollment period from July 15, 2009 through September 15, 2009 will be effective August 15, 2009. Applications submitted after September 15, 2009 will be effective the date of submission. No applications for Fall Semester 2009 are accepted after October 15, 2009.

Were you enrolled in SHIP during the previous semester? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, check one: <input type="checkbox"/> Registered Student <input type="checkbox"/> Filing Fee/Withdrawn	
Social Security Number:	Student ID:	Birth Date:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name:	First Name:	Academic Department:	
Street Address: _____		Telephone: (____) _____	
City/State or Country: _____ Zip: _____			
For office use only:			
Letter Date:	Check #:	<input type="checkbox"/> Withdrawn <input type="checkbox"/> Filing Fee <input type="checkbox"/> Concurrent	Medical Records: <input type="checkbox"/> 105 Expires 01/14/09
Effective Date of Coverage:			By: