

**UNIVERSITY OF CALIFORNIA RIVERSIDE**

**WAIVER CANCELLATION FORM**

Fax: (951) 827-7171

I AUTHORIZE THE STUDENT HEALTH INSURANCE DEPARTMENT TO  
CANCEL MY HEALTH INSURANCE WAIVER FORM FOR THE \_\_\_\_\_  
QUARTER OF THE ACADEMIC YEAR \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Student ID # / SS#