Please review the Benefit Booklet for a complete description of benefits, limitations, and plan procedures (including mandatory, binding arbitration procedures), before submitting this application. To obtain the Benefit Booklet, you can visit the UC SHIP website (www.ucop.edu/ucship), select the page for this campus, and follow the “Description of Benefits” link. You also can visit University Health Services to obtain a copy.

**REQUIRED DOCUMENTATION FOR DEPENDENT ENROLLMENTS (MUST ATTACH AND MAIL WITH THIS ENROLLMENT FORM):**

a) For spouse, a marriage certificate

b) For same-sex/opposite-sex domestic partner, a Declaration of Domestic Partnership issued by the State of California, or of same-sex legal union other than marriage formed in another jurisdiction, or a completed Declaration of Domestic Partnership form issued by the University. Please note: Opposite-sex partners are eligible for domestic partnership only if one or both partners are age 62 or older and eligible for Social Security benefits based on age

c) For natural child, a birth certificate showing the student is the parent of the child

d) For stepchild, a birth certificate, and a marriage certificate showing that one of the parents listed on the birth certificate is married to the student

e) For adopted or foster child, documentation from the placement agency showing that the student has the legal right to control the child’s health care
PREMIUMS are used by the University to pay for medical and pharmacy claims, dental insurance provided through Delta Dental, vision insurance provided through Anthem Blue View Vision, and the administrative fees paid to Anthem Blue Cross (medical claims administration), Wells Fargo Insurance Services (eligibility processing), Ventegra (pharmacy claims administration) and the University of California (program management).

PAYMENT METHOD (Remit in US Funds Only)

☐ Check/Money Order — MAKE CHECKS PAYABLE TO: Wells Fargo Insurance  Note: Premium is non-refundable unless you are found to be ineligible for the plan
☐ Credit Card: ☐ Visa ☐ MasterCard

Credit Card Account Number: ____________________________ Expires (month, year): ____________________________

Cardholder’s Name: ____________________________________________ (Print Cardholder’s name exactly as it appears on card.)

Enroll by phone (800) 853-5899, or send enrollment form, dependent documentation, and payment by mail or fax to:
Wells Fargo Insurance, 10940 White Rock Road, 2nd Floor, Rancho Cordova, CA 95670   •    Fax (877) 612-7966

This is limited term coverage only. Coverage will end on the last date specified in the plan you select, unless you enroll to continue insurance for an additional term. Premiums are calculated based on the plan term and will not be pro-rated. Coverage begins at 12:01 am and ends at midnight. It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment or fine. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

COMPLETE BOTH SIDES OF THE ENROLLMENT FORM AND SIGN BELOW

I attest by signing below that I have reviewed the information I have provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements. I have read and agree to the terms stated in the medical coverage Benefit Booklet and ( if vision coverage is elected or automatically included) the Blue View Vision Certificate of Insurance including the binding arbitration provisions. I AGREE TO HAVE ANY DISPUTE OR CLAIM RELATED TO UC SHIP MEDICAL OR VISION BENEFITS IN EXCESS OF THE JURISDICTIONAL LIMITS OF THE SMALL CLAIMS COURT DECIDED BY NEUTRAL ARBITRATION AND GIVE UP MY RIGHT TO A TRIAL BY COURT OR JURY. I have read and understand provisions described in the Delta Dental Evidence of Coverage booklet (if dental coverage is elected or automatically included with medical coverage). My signature below authorizes The University of California to provide Wells Fargo Insurance Services USA, Inc, with required information necessary in the event of a medical emergency. I understand my information is protected by privacy laws and will be released only in accordance the these laws. The only people who have access to this information are employees of my University, UC Office of the President (UCOP) and other third parties authorized by UCOP. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. I understand that, in other situations, you will ask me for written authorization to disclose information about me.

SIGNATURE OF STUDENT ____________________________ DATE ____________