❑ NEW
❑ RENEWING

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Wells Fargo Student Insurance Medical ID#

UC SANTA CRUZ UNDERGRADUATE STUDENT 2017-18 SHIP VOLUNTARY ENROLLMENT FORM

www.ucop.edu/ucship

VOLUNTARY UNDERGRADUATE STUDENT & DEPENDENT ENROLLMENT FORM

Please review the Benefit Booklet for a complete description of benefits, limitations, and plan procedures before submitting this application. To obtain the Benefit Booklet or to view the Summary of Benefits and Coverage (SBC), you can visit the UC SHIP website (*www.ucop.edu/ucship*), click on the PLAN DOCS tab on the home page and scroll to your campus to find your plan documents. You also can visit the Student Health Center website at www.shc.uci.edu, or call Anthem Blue Cross at 866-940-8306 to obtain a copy.

PLEASE PRINT CLEARLY

STUDENT'S NAME	LAST / SURNAME		
	FIRST NAME		MIDDLE INITIAL
STUDENT I.D. #	DATE OF BIRTH (Month, Day, Year)	SOCIAL SECURITY # (U.S. Citizens and Permanent Residents only)	
U.S. MAILING ADDRESS (Use school address if none)	STREET		APARTMENT #
CITY	STATE	ZIP	
PHONE #	EMAIL ADDRESS (REQUIRED)		

Please check appropriate box: ❑ FEMALE ❑ MALE	**Please check appropriate box:** ❑ SINGLE ❑ MARRIED/DOMESTIC PARTNER	**Please check appropriate box:** ❑ PLANNED EDUCATIONAL LEAVE (2 quarters max) ❑ SUMMER ❑ REGISTERED STUDENT ❑ CONTINUATION (Graduated and covered by UC SHIP in the term immediately preceding the term you are purchasing coverage. 1 quarter max)

PLEASE LIST DEPENDENTS TO BE INSURED BELOW. DEPENDENT COVERAGE IS AVAILABLE ONLY IF THE STUDENT IS ALSO INSURED. Please see the Benefit Booklet for complete benefits and contact information. (Dependents must be enrolled on the date the student is enrolled or within 30 days of a qualifying event)

LAST / SURNAME	FIRST NAME	MIDDLE INITIAL	GENDER	DATE OF BIRTH (Month/Day/Year)	SOCIAL SECURITY OR TAX I.D. # *(U.S. Citizens and Permanent Residents only)*
SPOUSE/DOMESTIC PARTNER:			❑ F ❑ M		
CHILD:			❑ F ❑ M		
CHILD:			❑ F ❑ M		
CHILD:			❑ F ❑ M		
CHILD:			❑ F ❑ M		

You can view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: *https://studentinsurance.wellsfargo.com* or call **800-853-5899** to request a paper copy free of charge.

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
f) **For child eligible by court order**, provide court documents which direct that the child will be covered under the insurance plan of the noncustodial parent

Questions? Call (800) 853-5899

PLEASE SEE OTHER SIDE FOR RATES AND PAYMENT INFORMATION. YOU MUST COMPLETE BOTH SIDES OF THIS ENROLLMENT FORM.

WELLS FARGO INSURANCE PRIVACY INFORMATION

We know that your privacy is important to you and we strive to protect the confidentiality of your personal information. We do not disclose any personal information about our plan participants, except as permitted or required by law (e.g., information you provide to us may be shared with your school to process your insurance transaction). To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. You may obtain a detailed copy of our privacy policy through your school or by calling us at **(800) 853-5899** or by visiting us at *https://studentinsurance.wellsfargo.com*.

PAYMENT IN FULL IS REQUIRED FOR THE TERM PURCHASED

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Premium is non-refundable and will not be pro-rated. Coverage is not automatically renewed. You must re-enroll each ACADEMIC term to maintain coverage. Notification of expiration of coverage will not be provided. See other side for required documentation for dependent enrollments.

PROGRAM COSTS

Terms of Coverage	FALL 9/23/17 - 1/4/18	WINTER 1/5/18 - 4/1/18	SPRING/SUMMER 4/2/18 - 9/21/18	SUMMER 6/15/18 - 9/21/18
Enrollments will not be processed prior to the enrollment start date. Please submit your form or call Wells Fargo Student Insurance to enroll during the enrollment period.				
Enrollment Start Date	**8/23/17**	**12/5/17**	**3/2/18**	**5/15/18**
Enrollment Deadline	**10/24/17**	**2/5/18**	**5/3/18**	**7/16/18**
Voluntary Student only (Medical, Dental and Vision)	❑ $1,625.57	❑ $1,625.57	❑ $1,625.57	❑ $1,625.57
Dependent coverage is voluntary, is in addition to student coverage, and must be purchased for the same term of insurance as the student's plan.				
Spouse/Domestic Partner Only (Medical Only Coverage)	❑ $2,900.00	❑ $2,900.00	❑ $2,900.00	❑ $2,900.00
Spouse/Domestic Partner Only (Medical, Dental and Vision)	❑ $2,966.35	❑ $2,966.35	❑ $2,966.35	❑ $2,966.35
Child(ren) Only (Medical Only Coverage)	❑ $2,503.00	❑ $2,503.00	❑ $2,503.00	❑ $2,503.00
Child(ren) Only (Medical, Dental and Vision)	❑ $2,567.72	❑ $2,567.72	❑ $2,567.72	❑ $2,567.72
Family coverage is voluntary, is in addition to student coverage, and must be purchased for the same term of insurance as the student's plan.				
Spouse/Domestic Partner and Child(ren) (Medical Only Coverage)	❑ $5,296.67	❑ $5,296.67	❑ $5,296.67	❑ $5,296.67
Spouse/Domestic Partner and Child(ren) (Medical, Dental and Vision)	❑ $5,413.01	❑ $5,413.01	❑ $5,413.01	❑ $5,413.01

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 Student Insurance (eligibility processing), and OptumRx (pharmacy claims administration) and the University of California (program management).

PAYMENT METHOD (Remit in US Funds Only)

Note: Premium is non-refundable unless you are found to be ineligible for the plan

NOTE: If we are unable to process your payment (due to insufficient funds, closure of account, etc.), you and/or your dependents' insurance coverage will be terminated retro-active to the effective date of the enrolled term and you will be responsible for any incurred claims.

❑ **Check/Money Order –** MAKE CHECKS PAYABLE TO: Wells Fargo Student Insurance

❑ **Credit Card:** ❑ Visa ❑ MasterCard ❑ Discover

Credit Card Account Number:	Expires (month, year):
Cardholder's Name:	

(Enter/Print Cardholder's name exactly as it appears on card.)

Mail or fax enrollment form and payment to: Wells Fargo Student 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 Plan Booklet including the binding arbitration provisions. I AGREE TO HAVE ANY DISPUTE OR CLAIM RELATED TO UC SHIP 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 Student Insurance 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** _____