2018-19 UC LOS ANGELES LAW STUDENT
SHIP VOLUNTARY ENROLLMENT FORM

www.ucop.edu/ucship

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 Student Health Services, or call Anthem Blue Cross at 1-866-940-8306 to obtain a copy.

PLEASE PRINT CLEARLY

<table>
<thead>
<tr>
<th>STUDENT'S NAME</th>
<th>LAST / SURNAME</th>
<th>FIRST NAME</th>
<th>MIDDLE INITIAL</th>
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<tbody>
<tr>
<td>STUDENT I.D. #</td>
<td>DATE OF BIRTH (Month, Day, Year)</td>
<td>SOCIAL SECURITY # (U.S. Citizens and Permanent Residents only)</td>
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<td>U.S. MAILING ADDRESS (Use school address if none)</td>
<td>STREET</td>
<td>APARTMENT #</td>
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<td>PHONE #</td>
<td>EMAIL ADDRESS (REQUIRED)</td>
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Please check appropriate box:

- [ ] FEMALE
- [ ] MALE
- [ ] SINGLE
- [ ] MARRIED/DOMESTIC PARTNER
- [ ] DOMESTIC
- [ ] INTERNATIONAL
- [ ] APPROVED LEAVE OF ABSENCE (1 semester max)
- [ ] CONTINUATION (1 semester 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)

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<tr>
<th>LAST / SURNAME</th>
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<th>MIDDLE INITIAL</th>
<th>GENDER</th>
<th>DATE OF BIRTH (Month/Day/Year)</th>
<th>SOCIAL SECURITY OR TAX I.D. # (U.S. Citizens and Permanent Residents only)</th>
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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 1-855-428-0727 or email ucship@ahpservice.com

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

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 Academic HealthPlans 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 with 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__________________________