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.
PROGRAM COSTS

<table>
<thead>
<tr>
<th>Terms of Coverage</th>
<th>FALL 1ST YEAR</th>
<th>FALL 2ND YEAR</th>
<th>FALL 3RD YEAR</th>
<th>FALL 4TH YEAR</th>
<th>SPR/SUM 1ST YEAR</th>
<th>SPR/SU 2ND YEAR</th>
<th>SPR/SU 3RD YEAR</th>
<th>SPR/SU 4TH YEAR</th>
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Enrollments will not be processed prior to the enrollment start date. Please submit your form or call Academic HealthPlans to enroll during the enrollment period.

Enrollment Start Date: 7/6/19, 6/28/19, 7/12/19, 6/8/19, 12/6/19, 12/3/19, 12/2/19, 12/6/19

Enrollment Deadline: 9/6/19, 8/30/19, 9/13/19, 8/8/19, 2/6/20, 2/3/20, 2/3/20, 2/6/20

NOTE: The final cost will include a 3% processing fee if paying with credit card.

ENROLLMENT TERMS & Coverage will be effective the date the correct premium is received by the Company, or an authorized representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing below, the student acknowledges the following: 1) Rates are not prorated other than as listed on this enrollment form; 2) Student meets the eligibility requirements for this coverage as described in the brochure; 3) If it is later determined that the student is not eligible, coverage will be deemed to have not been in force and the premium will be returned; and 4) Other than entry into the Armed Forces, the premium is not refundable. It is the student’s responsibility to make a timely renewal payment. This plan is underwritten by Anthem Blue Cross.

PAYMENT METHOD (Remit in US Funds Only)

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 retroactive to the effective date of the enrolled term and you will be responsible for any incurred claims.

☐ Check/Money Order – MAKE CHECKS PAYABLE TO: Academic HealthPlans
☐ Credit Card:
  ☐ AMEX  ☐ Visa  ☐ MasterCard  ☐ Discover

Check Number:  
Check Amount: $

Credit Card Account Number:  
Billing Zip Code:  
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: Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605  •  ucship@ahpservice.com  •  Fax 1-855-858-1964

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). 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_