Required Documentation for Dependent Enrollments (Must Attach and Mail with This Enrollment Form):

- For spouse, a marriage certificate
- 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
- For natural child, a birth certificate showing the student is the parent of the child
- 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
- 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
- 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.
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**

<table>
<thead>
<tr>
<th>Terms of Coverage</th>
<th>FALL 1ST &amp; 2ND YEAR</th>
<th>FALL 3RD YEAR</th>
<th>FALL 4TH YEAR</th>
<th>SPRING/SUMMER 1ST &amp; 2ND YEAR</th>
<th>SPRING/SUMMER 3RD YEAR</th>
<th>SPRING/SUMMER 4TH YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7/31/18 - 1/2/19</td>
<td>8/14/18 - 1/2/19</td>
<td>7/10/18 - 1/2/19</td>
<td>1/3/19 - 7/29/19</td>
<td>1/3/19 - 8/12/19</td>
<td>1/3/19 - 7/8/19</td>
</tr>
</tbody>
</table>

**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.**

**FALL**
- Enrollment Start Date: 6/30/18
- Enrollment Deadline: 8/31/18

**SPRING/SUMMER**
- Enrollment Start Date: 2/3/19
- Enrollment Deadline: 3/3/19

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.

<table>
<thead>
<tr>
<th>Family Coverage Options</th>
<th>FALL (Medical Only Coverage)</th>
<th>SPRING/SUMMER (Medical Only Coverage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Domestic Partner only</td>
<td>$3,119.00</td>
<td>$3,119.00</td>
</tr>
<tr>
<td>Child(ren) Only</td>
<td>$2,697.00</td>
<td>$2,697.00</td>
</tr>
</tbody>
</table>
| Family Coverage Voluntary, is in addition to student coverage, and must be purchased for the same term of insurance as the student's plan.

**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 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.

**PAYMENT METHOD** (Remit in US Funds Only)

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

- Credit Card Options: AMEX, Visa, MasterCard, Discover
- Check/Money Order: PAYABLE TO: Academic HealthPlans

**Credit Card Account Number:**

**Cardholder's Name:**

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

**Mail or fax enrollment form and payment to:** Academic HealthPlans, 3500 William D. Tate Ave., Suite 200, Grapevine, TX 76051 • 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.**

**SIGNATURE OF STUDENT**

**DATE**