❑ NEW
❑ RENEWING
8 0
Wells Fargo Insurance Medical ID#

UCSHIP

VOLUNTARY STUDENT & DEPENDENT ENROLLMENT FORM

# UC MERCED VOLUNTARY GRADUATE STUDENT HEALTH INSURANCE PLAN
# 2015-2016 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*), select the page for this campus, and follow the "Description of Benefits" link. You also can visit Student Health Services, or call Anthem Blue Cross at 866-940-8306 to obtain a copy.

| | | | |
|---|---|---|---|
| STUDENT'S NAME | LAST / SURNAME | | |
| | FIRST NAME | | MIDDLE INITIAL |
| STUDENT I.D. # | DATE OF BIRTH *(Month, Day, Year)* | SOCIAL SECURITY OR TAX I.D. # *(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:* ❑ DOMESTIC ❑ INTERNATIONAL | *Please check appropriate box:* ❑ FILING FEE STATUS (1 semester max) ❑ PLANNED EDUCATIONAL LEAVE or APPROVED WITHDRAWAL (1 semester max) ❑ CONTINUATION (Graduated in immediately preceding term. 1 semester max) |

PLEASE LIST DEPENDENTS TO BE INSURED BELOW. DEPENDENT COVERAGE IS AVAILABLE ONLY IF THE STUDENT IS ALSO INSURED. Please note that benefits and coverage levels for dependents differ from those of students. 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 *(M/F)* | DATE OF BIRTH *(Month, Day, Year)* | SOCIAL SECURITY OR TAX I.D. # *(U.S. Citizens and Permanent Residents only)* |
|---|---|---|---|---|---|
| SPOUSE/DOMESTIC PARTNER: | | | | | |
| CHILD: | | | | | |
| CHILD: | | | | | |
| CHILD: | | | | | |
| CHILD: | | | | | |

## 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

***Questions? Call (800) 853-5899.***

*PLEASE SEE OTHER SIDE FOR 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 ***studentinsurance.wellsfargo.com***.

PAYMENT IN FULL IS REQUIRED FOR THE TERM PURCHASED

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## 2015-2016 ENROLLMENT FORM
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VOLUNTARY STUDENT & DEPENDENT ENROLLMENT FORM

COVERAGE IS NOT AUTOMATICALLY RENEWED. YOU MUST RE-ENROLL EACH TERM TO MAINTAIN COVERAGE. NOTIFICATION OF EXPIRATION OF COVERAGE WILL NOT BE PROVIDED.
SEE OTHER SIDE FOR REQUIRED DOCUMENTATION FOR DEPENDENT ENROLLMENTS.

| | FALL<br>8/15/15 - 1/14/16 | SPRING/SUMMER<br>1/15/16 - 8/14/16 |
|---|---|---|
| **Enrollments will not be processed prior to the enrollment start date. Please submit your form or call Wells Fargo Insurance to enroll during the enrollment period.** | | |
| Enrollment Start Date | 7/15/15 | 12/15/15 |
| Enrollment Deadline | 9/15/15 | 2/15/16 |
| Student (Medical, Dental and Vision) | ❑$837.52 | ❑$1,172.52 |
| **Dependent coverage 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<br>(Medical Only Coverage) | ❑$745.42 | ❑$1,043.58 |
| Spouse/Domestic Partner Only<br>(Medical, Dental and Vision) | ❑$840.62 | ❑$1,176.86 |
| Child(ren) Only<br>(Medical Only Coverage) | ❑$745.42 | ❑$1,043.58 |
| Child(ren) Only<br>(Medical, Dental and Vision) | ❑$842.22 | ❑$1,179.10 |
| **Family Coverage 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)<br>(Medical Only Coverage) | ❑$745.42 | ❑$1,043.58 |
| Spouse/Domestic Partner and Child(ren)<br>(Medical, Dental and Vision) | ❑$927.32 | ❑$1,298.24 |

*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 (before 8/1/15) and Catamaran (after 8/1/15) (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 ❑ Discover

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 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 _____