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.
Terms of Coverage | FALL 1 8/1/17 - 12/31/17 | FALL 2 9/1/17 - 12/31/17 | WINTER 1/1/18 - 4/1/18 | SPRING 4/2/18 - 6/17/18 | SUMMER 6/18/18 - 8/31/18
--- | --- | --- | --- | --- | ---
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 | 7/1/17 | 8/1/17 | 12/1/17 | 3/2/18 | 5/18/18
Enrollment Deadline | 9/1/17 | 10/2/17 | 2/2/18 | 5/3/18 | 7/19/18

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)**: $2,148.61
- **Spouse/Domestic Partner Only (Medical, Dental and Vision)**: $2,214.73
- **Child(ren) Only (Medical Only Coverage)**: $1,638.00
- **Child(ren) Only (Medical, Dental and Vision)**: $1,703.53

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)**: $3,705.86
- **Spouse/Domestic Partner and Child(ren) (Medical, Dental and Vision)**: $3,827.39

Program Costs are determined 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)

- **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.

Signature of Student: _______________________________ Date: __________