UC SHIP MEMBER ID

2019-20 UC SAN FRANCISCO GRADUATE STUDENT SHIP VOLUNTARY ENROLLMENT FORM

www.ucop.edu/ucship

VOLUNTARY STUDENT & DEPENDENT ENROLLMENT FORM

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.

STUDENT'S NAME	LAST / SURNAME		
	FIRST NAME		MIDDLE INITIAL
STUDENT I.D. #	DATE OF BIRTH (Month, Day, Year)	SOCIAL SECURITY # (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:
❑ DOMESTIC ❑ INTERNATIONAL

Please check appropriate box:
❑ SINGLE ❑ MARRIED/DOMESTIC PARTNER

Please check appropriate box:
❑ FILING FEE STATUS (1 quarter/1 semester max)
❑ PLANNED EDUCATIONAL LEAVE or APPROVED WITHDRAWAL (LOA)(2 quarters/1 semester max)
❑ CONTINUATION (Graduated in immediately preceding term. 1 quarter/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)

LAST / SURNAME	FIRST NAME	MIDDLE INITIAL	GENDER	DATE OF BIRTH (Month/Day/Year)	SOCIAL SECURITY OR TAX I.D. # *(U.S. Citizens and Permanent Residents only)*
SPOUSE/DOMESTIC PARTNER:			❑ F ❑ M		
CHILD:			❑ F ❑ M		
CHILD:			❑ F ❑ M		
CHILD:			❑ F ❑ M		

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

PAYMENT METHOD (Remit in US Funds Only) • ***Note: Premium is non-refundable unless you are found to be ineligible for the plan***

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** **Check Number:** **Check Amount: $**

❑ **Credit Card:** ❑ AMEX ❑ Visa ❑ MasterCard ❑ Discover **NOTE: The final cost will include a 3% processing fee if paying with credit card.**

Credit Card Account Number:	Billing Zip Code:	Expires (month, year):
Cardholder's Name:		

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

If payment is by check, please mail your check & enrollment form to: Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605. Credit card payments can be emailed to ucship@ahpservice.com or faxed to 1-855-858-1964. If you're enrolling a dependent, please also provide documentation.

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). 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** _____

PAYMENT IN FULL IS REQUIRED FOR THE TERM PURCHASED

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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

Terms of Coverage	FALL GRAD DIVISION 9/1/19 -12/31/19	WINTER GRAD DIVISION 1/1/20 - 3/29/20	SPRING GRAD DIVISION 3/30/20 - 6/14/20	SUMMER GRAD DIVISION 6/15/20 - 8/31/20
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	**8/1/19**	**12/2/19**	**2/28/20**	**5/15/20**
Enrollment Deadline	**10/2/19**	**1/31/20**	**4/30/20**	**7/16/20**
Student Only (Medical, Dental and Vision)	❑ $1,698.88	❑ $1,698.88	❑ $1,698.88	❑ $1,698.88
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)	❑ $2,329.69	❑ $2,329.69	❑ $2,329.69	❑ $2,329.69
Spouse/Domestic Partner Only (Medical, Dental and Vision)	❑ $2,404.72	❑ $2,404.72	❑ $2,404.72	❑ $2,404.72
Child(ren) Only (Medical Only Coverage)	❑ $1,771.25	❑ $1,771.25	❑ $1,771.25	❑ $1,771.25
Child(ren) Only (Medical, Dental and Vision)	❑ $1,846.54	❑ $1,846.54	❑ $1,846.54	❑ $1,846.54
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)	❑ $4,013.68	❑ $4,013.68	❑ $4,013.68	❑ $4,013.68
Spouse/Domestic Partner and Child(ren) (Medical, Dental and Vision)	❑ $4,154.14	❑ $4,154.14	❑ $4,154.14	❑ $4,154.14

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

ENROLLMENT TERMS & CONDITIONS: 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.

Questions? Call 1-855-428-0723 or email ucship@ahpservice.com

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