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

DEPENDENT ENROLLMENT FORM

UC HASTINGS GRADUATE STUDENT HEALTH INSURANCE PLAN
2013-2014 ENROLLMENT FORM FOR DEPENDENTS OF REGISTERED STUDENTS

www.ucop.edu/ucship

STUDENT'S NAME _____ (Last Name (Family Name) / First / MI)

STUDENT ID # _____ DATE OF BIRTH _____ (Mo. / Day / Year)

PERMANENT U.S. MAILING ADDRESS _____ (Street / Apt. #)

_____ (City / State / Zip)

PHONE # _____ E-MAIL ADDRESS _____

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 NAME	FIRST NAME	MI	GENDER	DATE OF BIRTH
SPOUSE/ DOMESTIC PARTNER					
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 rates and payment information.

YOU MUST COMPLETE BOTH SIDES OF THIS ENROLLMENT FORM.

PAYMENT IN FULL IS REQUIRED FOR THE TERM PURCHASED

UC HASTINGS GRADUATE STUDENT HEALTH INSURANCE PLAN
2013-2014 ENROLLMENT FORM FOR DEPENDENTS OF REGISTERED STUDENTS

www.ucop.edu/ucship

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.

	FALL LLM & LEOP 8/5/13 - 1/8/14	FALL 8/12/13 - 1/8/14	SPRING/SUMMER FES 1/8/14 - 8/10/14	SPRING/SUMMER 1/9/14 - 8/10/14
Enrollments will not be processed prior to the enrollment start date. Please submit your form or call to enroll during the enrollment period.				
Enrollment Start Date	7/5/13	7/12/13	12/8/13	12/9/13
Enrollment Deadline	9/5/13	9/12/13	2/9/14	2/10/14
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 (Medical Only Coverage)	❑$2,264.02	❑$2,264.02	❑$3,169.63	❑$3,169.63
Spouse/Domestic Partner Only (Medical, Dental and Vision)	❑$2,374.42	❑$2,374.42	❑$3,324.19	❑$3,324.19
Child(ren) Only (Medical Only Coverage)	❑$1,954.84	❑$1,954.84	❑$2,736.77	❑$2,736.77
Child(ren) Only (Medical, Dental and Vision)	❑$2,068.49	❑$2,068.49	❑$2,895.88	❑$2,895.88
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) (Medical Only Coverage)	❑$4,131.80	❑$4,131.80	❑$5,784.53	❑$5,784.53
Spouse/Domestic Partner and Child(ren) (Medical, Dental and Vision)	❑$4,346.65	❑$4,346.65	❑$6,085.32	❑$6,085.32

PAYMENT METHOD *(Premium is NON-REFUNDABLE):*

❑ Check/Money Order payable to Wells Fargo Insurance *(US funds only. Coverage will be cancelled and a $25.00 fee will be assessed for insufficient funds.)*

Credit Card: ❑ Visa ❑ Master Card

Account No. ____________________ Expires: ________

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 (see reverse) and payment by mail or fax: *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 provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements and I have read and understand the Benefit Booklet. 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 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. In other situations, we will ask you for written authorization to disclose information about you.

SIGNATURE OF STUDENT ______________________________ DATE ____________________