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 1-855-427-3206 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 LLM EARLY START 8/8/19 - 9/22/19</th>
<th>FALL GRADUATE TAX PROGRAM &amp; 1ST YEAR LAW EARLY START 8/13/19 - 9/22/19</th>
<th>FALL CONTINUING LAW 9/23/19 - 1/1/20</th>
<th>SPRING/SUMMER 1/2/20 - 9/27/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Only (Medical, Dental and Vision)</td>
<td>$552.46</td>
<td>$492.41</td>
<td>$3,939.77</td>
<td>$3,939.77</td>
</tr>
</tbody>
</table>

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) | $ 957.72                          | $ 853.62                          | $ 3,799.00                          | $ 3,799.00                          |
| Spouse/Domestic Partner Only (Medical, Dental and Vision) | $1,001.88                          | $ 892.98                          | $ 3,971.06                          | $ 3,971.06                          |
| Child(ren) Only (Medical Only Coverage)              | $ 827.54                          | $ 737.59                          | $ 3,282.50                          | $ 3,282.50                          |
| Child(ren) Only (Medical, Dental and Vision)         | $ 871.70                          | $ 776.95                          | $ 3,457.07                          | $ 3,457.07                          |

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) Only (Medical Only Coverage) | $1,738.34                          | $1,549.39                          | $ 6,895.00                          | $ 6,895.00                          |
| Spouse/Domestic Partner and Child(ren) (Medical, Dental and Vision) | $1,821.14                          | $1,623.19                          | $7,222.91                          | $7,222.91                          |

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

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

Select your method of payment:
- [ ] Check/Money Order – MAKE CHECKS PAYABLE TO: Academic HealthPlans
- [ ] Credit Card: [ ] AMEX [ ] Visa [ ] MasterCard [ ] Discover

Enter Payment Information:
- Check Number:
- Check Amount: $
- Credit Card Account Number:
- Billing Zip Code:
- Expires (month, year):

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 made to ucship@ahpservice.com or faxed to 1-855-858-1964. If you’re enrolling a dependent, please also provide documentation.

### 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 ________________________________