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 Student Health Center website (www.shc.uci.edu) or call 949-824-2388 to obtain a copy.

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 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.
**UC IRVINE VOLUNTARY UNDERGRADUATE STUDENT HEALTH INSURANCE PLAN (USHIP)**

2017 TRANSFER EDGE ENROLLMENT FORM

**PAYMENT IN FULL IS REQUIRED FOR THE TERM PURCHASED**

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.

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Enrollment Start Date</td>
<td>5/26/17</td>
<td>5/26/17</td>
</tr>
<tr>
<td>Enrollment Deadline</td>
<td>7/25/17</td>
<td>7/25/17</td>
</tr>
<tr>
<td>Student Only (Medical, Dental and Vision)</td>
<td>□ $280.12</td>
<td>□ $422.48</td>
</tr>
<tr>
<td>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.</td>
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<tr>
<td>Spouse/Domestic Partner Only (Medical, Dental and Vision)</td>
<td>□ $280.18</td>
<td>□ $422.57</td>
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<tr>
<td>Child(ren) Only (Medical, Dental and Vision)</td>
<td>□ $279.84</td>
<td>□ $422.05</td>
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<tr>
<td>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.</td>
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</tr>
<tr>
<td>Spouse/Domestic Partner and Child(ren) Only (Medical, Dental and Vision)</td>
<td>□ $795.70</td>
<td>□ $1,200.08</td>
</tr>
</tbody>
</table>

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 medical insurance provided through Anthem Blue Cross, Wells Fargo Student Insurance (eligibility processing), and the University of California (dental and vision 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

<table>
<thead>
<tr>
<th>Credit Card Account Number:</th>
<th>Expires (month, year):</th>
</tr>
</thead>
</table>

(Put 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 Student Insurance, 10940 White Rock Road, 2nd Floor, Rancho Cordova, CA 95670 • Fax (877) 612-7966

Coverage is not automatically renewed. 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 prorated. 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.

Please read carefully and sign below

**REQUIREMENT FOR BINDING ARBITRATION**

The following provision does not apply to class actions:

If you are applying for coverage, please note that Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company require binding arbitration to settle all disputes including but not limited to disputes relating to the delivery of service under the plan or any other issues related to the plan and claims of medical malpractice. If the amount in dispute exceeds the jurisdictional limit of small claims court, California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.

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 Plan Brochure. My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept as applicable to me the terms and conditions stated therein. It also authorizes my school to provide Wells Fargo Student Insurance with required information necessary in the event of a medical emergency.

**SIGNATURE OF STUDENT** ____________________________ **DATE** ___________