USHIP Undergraduate Student Health Insurance Plan

2013–2014 Enrollment Form

For Continuation Coverage in the DEPENDENT Plan

UNIVERSITY OF CALIFORNIA IRVINE
Nationwide Life Insurance Company
POLICY NUMBER 302-136-0411

COMPLETE THE INFORMATION BELOW. PLEASE PRINT CLEARLY. FOR QUESTIONS ABOUT ENROLLMENT, CONTACT ASCENSION AT 1-800-537-1777.

1. ENTER STUDENT INFORMATION:

STUDENT'S LAST NAME	STUDENT'S FIRST NAME	MIDDLE INITIAL
STUDENT'S PERMANENT U.S. MAILING ADDRESS—NUMBER AND STREET NAME		APT#/P.O. BOX#
CITY	STATE / ZIP	
STUDENT'S PHONE NUMBER	STUDENT'S DATE OF BIRTH (MM/DD/YY) / /	❑ FEMALE ❑ MALE
STUDENT'S EMAIL ADDRESS	STUDENT'S SCHOOL ID NUMBER	

2. ARE YOU CURRENTLY INSURED UNDER USHIP? ❑ NO ❑ YES

3. PLEASE SELECT THE TERM OF CONTINUATION COVERAGE YOU WOULD LIKE TO PURCHASE (ONE TERM ONLY):

MEDICAL ONLY			
CURRENT COVERAGE TERMINATION DATE	*09/23/13*	*01/02/14*	*03/26/14*
DATES OF CONTINUATION COVERAGE	**09/23/13 to 01/02/14**	**01/02/14 to 03/26/14**	**03/26/14 to 09/29/14**
ENROLLMENT DEADLINE DATE	**10/23/13**	**02/02/14**	**04/26/14**
SPOUSE/ DOMESTIC PARTNER PREMIUM – MEDICAL ONLY	❑ $ 2,267.00	❑ $ 2,267.00	❑ $ 2,267.00
CHILD(REN) PREMIUM – MEDICAL ONLY	❑ $ 1,943.00	❑ $ 1,943.00	❑ $ 1,943.00
TOTAL	$	$	$

*THE COSTS OF COVERAGE INCLUDE MEDICAL INSURANCE PREMIUM AND ADMINISTRATIVE FEES **ONLY**.*

4. IF YOU ARE ENROLLING IN THE DENTAL & VISION PLAN, COMPLETE ENROLLMENT BY CALLING **1-800-853-5899.** DEPENDENTS MAY ENROLL IN MEDICAL ONLY, OR MEDICAL, DENTAL & VISION COMBINED. FOR MORE INFORMATION, VISIT **www.shc.uci.edu.**

5. PLEASE ENTER DEPENDENT INFORMATION BELOW:

DEPENDENTS MAY BE ENROLLED ONLY IF THE STUDENT IS ALSO ENROLLED.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YY)	GENDER
SPOUSE/DOMESTIC PARTNER				❑ FEMALE ❑ MALE
CHILD				❑ FEMALE ❑ MALE
CHILD				❑ FEMALE ❑ MALE
CHILD				❑ FEMALE ❑ MALE

6. MAKE CHECK OR MONEY ORDER PAYABLE TO: **ASCENSION BENEFITS & INSURANCE SOLUTIONS**
OR COMPLETE CREDIT CARD INFORMATION BELOW:

CREDIT CARD AUTHORIZATION: CHARGE WILL APPEAR AS **"STUDENT HEALTH INSURANCE, ASCENSION"** ON YOUR CREDIT CARD BILL.																
MASTERCARD # OR VISA #																
NAME OF CARDHOLDER (PLEASE PRINT)									CHARGE AMOUNT:	$				EXPIRATION DATE _____/_____		
SIGNATURE OF CARDHOLDER																

7. STUDENT SIGNATURE:

I CERTIFY THAT I AM GRADUATING FROM UNIVERSITY OF CALIFORNIA IRVINE IMMEDIATELY PRECEDING THE TERM FOR WHICH I AM ENROLLING. I UNDERSTAND THAT I MAY PURCHASE THE CONTINUATION COVERAGE ONLY ONCE PER LIFETIME. I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS AND CONDITIONS OF COVERAGE AS OUTLINED IN THE PLAN BROCHURE.

SIGNATURE X_____ DATE_____

8. RETURN THIS FORM WITH PAYMENT TO: **ASCENSION, P.O. BOX 240042, LOS ANGELES, CA 90024**

MUST BE POSTMARKED BY THE APPLICABLE DEADLINE DATE.