

**UNIVERSITY OF CALIFORNIA, SANTA CRUZ - STUDENT HEALTH INSURANCE
2008-2009 GSHIP ENROLLMENT FORM**

FALL QUARTER

Underwritten by Anthem Blue Cross Life and Health Insurance Company

STUDENT'S NAME _____
Last First MI

PERMANENT U.S. MAILING ADDRESS (Street Address) _____

CITY, STATE AND ZIP _____

PHONE NUMBER _____ STUDENT ID# _____

DATE OF BIRTH ____/____/____
mo. day year E-MAIL ADDRESS _____

FEMALE MALE MARRIED SINGLE PART TIME LOA (will be returning Fall, Winter or Spring Quarter)

*LIST DEPENDENTS TO BE INSURED BELOW. DEPENDENT COVERAGE IS AVAILABLE **ONLY** IF THE STUDENT IS ALSO INSURED.
DEPENDENTS MUST BE ENROLLED ON THE DATE THE STUDENT IS ENROLLED OR WITHIN 31 DAYS OF DATE OF BIRTH, MARRIAGE, OR ARRIVAL IN THE U.S.*

	LAST NAME	FIRST NAME	MI	GENDER	DATE OF BIRTH
SPOUSE	_____	_____	_____	_____	_____
CHILD	_____	_____	_____	_____	_____
CHILD	_____	_____	_____	_____	_____
CHILD	_____	_____	_____	_____	_____

PROGRAM COSTS

	FALL - HEALTH 9/20/08 - 1/4/09	FALL - DENTAL 9/20/08 - 1/4/09	FALL - VISION 9/20/08 - 1/4/09
Waiver Deadline	9/17/08	9/17/08	9/17/08
Student**	<input type="checkbox"/> \$641	<input type="checkbox"/> \$132	<input type="checkbox"/> \$28
Spouse**	<input type="checkbox"/> \$1,074		
Child(ren)** age 18 and under, 23 if a full-time student.	<input type="checkbox"/> \$867		

*Costs are inclusive of UCSC Student Health Center access plan and administrative fees.
**Costs are inclusive of administrative fees.

PAYMENT METHOD (Remit in US Funds Only):

MAKE CHECKS OR MONEY ORDERS PAYABLE TO: **UC REGENTS**

(If you write a check to pay for your insurance and it is returned for insufficient funds, your insurance will be cancelled as of the effective date of coverage. If you still wish to be covered, you will have to pay the required premium plus a \$25.00 fee for insufficient funds.)

RETURN PAYMENT AND ENROLLMENT FORM TO:

**SHC Insurance Office, 1156 High Street, University of California, Santa Cruz, CA 95064
(831) 459-2389**

**PAYMENT IN FULL REQUIRED
FOR TERM PURCHASED**

PLEASE READ CAREFULLY AND SIGN BELOW

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross Life and Health approval.

ARBITRATION AGREEMENT: I understand that any and all disputes between myself (and/or any enrolled family member) and Anthem Blue Cross Life and Health, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and Anthem Blue Cross Life and Health are giving up the right to have any dispute decided in a court of law before a jury. Anthem Blue Cross Life and Health and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. (For more information regarding binding arbitration, please refer to your Evidence of Coverage Certificate.)

COVERAGE IS NOT AUTOMATICALLY RENEWED. Eligible Persons must re-enroll when coverage terminates to maintain coverage.

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.

DATE _____ SIGNATURE OF STUDENT _____