

RETIREE CONTINUATION, ENROLLMENT, OR CHANGE—MEDICAL, DENTAL AND/OR LEGAL PLAN

UBEN 100 (R10/04) University of California Human Resources and Benefits

Send completed form to: UC Human Resources and Benefits
Health and Welfare Administration
P.O. Box 24570
Oakland, CA 94623-1570

1. PERSONAL INFORMATION

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	CAMPUS/LAB LOCATION	RETIREMENT SYSTEM COVERAGE <input type="checkbox"/> UCRP <input type="checkbox"/> CalPERS <input type="checkbox"/> OTHER (Specify):
ADDRESS (Number, Street)		(City, State, ZIP)	

2. ACTIONS

Add eligible family member(s):

Spouse (date of marriage: _____)

Domestic partner registered with State of CA (filing date: _____)

Domestic partner not registered with State of CA. I certify I can provide required documentation to verify eligibility. (date partnership began: _____)

Other eligible family member

Change plans/enroll during Open Enrollment or during a Period of Initial Eligibility

Move out of/return to plan's service area (date: _____)

Delete family member (effective date: _____); for following reason:

Divorce, legal separation, annulment

Termination of domestic partnership registered with State of CA (filing date of termination: _____)

Termination of partnership not registered with State of CA (date relationship ended: _____)

Loss of eligibility for dependent child status

Loss of eligibility for adult dependent relative

Deceased

Other: _____

Transfer coverage from employment to: retirement disability other: _____

I have TRICARE For Life; I wish to suspend or enroll in medical plan coverage

Suspend medical plan coverage. I have other group/individual coverage.

Medical Plan	ENROLL	CANCEL	Western Heath Advantage ¹	ENROLL	CANCEL	UnitedHealthcare Select EPO ¹	ENROLL	CANCEL	Dental Plan	ENROLL	CANCEL	Legal Plan	ENROLL	CANCEL
Health Net ¹	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Delta Dental	<input type="checkbox"/>	<input type="checkbox"/>	ARAG Legal Plan	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser-CA ¹	<input type="checkbox"/>	<input type="checkbox"/>	Blue Cross PLUS ^{1,2}	<input type="checkbox"/>	<input type="checkbox"/>	UnitedHealthcare Options PPO ³	<input type="checkbox"/>	<input type="checkbox"/>	PMI (CA)	<input type="checkbox"/>	<input type="checkbox"/>	(Available during announced Open Enrollment periods.)		
PacifiCare-CA ¹	<input type="checkbox"/>	<input type="checkbox"/>	Blue Cross PPO ²	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>						
Core	<input type="checkbox"/>	<input type="checkbox"/>	High Option ^{2,4}	<input type="checkbox"/>	<input type="checkbox"/>									

1 You must live in plan's service area
2 Not available to LANL retirees
3 Not available to CA retirees
4 Call the UC Customer Service Center (1-800-888-8267) for eligibility information

3. ENROLLEE INFORMATION

LIST YOURSELF AND ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED. Enter the Relationship Code below: **You may only enroll one adult other than yourself:** Legal Spouse (S), Adult Dependent Relative (A) (may not enroll after 12/31/03), Same-Sex Domestic Partner (D), Opposite-Sex Domestic Partner (L); **Eligible Children:** Natural or Adopted Child (C), Partner's Child/Grandchild (K), Stepchild (P), Legal Ward (W), Grandchild (G), Other Child (O) (enrolled before 9/1/94), Non-Tax Dependent Overage Disabled Child (N)

1.	Name (Last, First, MI)	Sex	Relationship (see above)	Birthdate MO DY YR	Social Security number (required)	✓ TO ENROLL			Primary Care Physician or Medical Group I.D. (if required, and this section is blank, one will be assigned)	Check if Current Physician
						Med	Dent	Leg		
	RETIREE LISTED IN SECTION 1		RETIREE		LISTED IN SECTION 1			LISTED IN SECTION 2		
2.										
3.										
4.										

4. MEDICARE (For any member age 65 or older or others eligible to enroll or enrolling in Medicare) Send UC HR/Benefits a copy of the Medicare card(s) when enrolled.

The following are enrolled in Medicare: (Enter effective dates, claim number, and provide a copy of the Medicare card.) Check if any family members are in the process of enrolling in Medicare.

Retiree				Retiree's Spouse or Domestic Partner				Adult Dependent Relative (does not qualify for UC coverage if eligible for Medicare Part A)				Eligible Child							
Effective Date	Medicare Part A:	MO	DY	YR	Effective Date	Medicare Part A:	MO	DY	YR	Effective Date	Medicare Part A:	MO	DY	YR	Effective Date	Medicare Part A:	MO	DY	YR
CLAIM NUMBER:				CLAIM NUMBER:				CLAIM NUMBER:				CLAIM NUMBER:							

5. SIGNATURE: I have read and agree to the "Terms and Conditions" on the back of this form. I certify under under penalty of perjury that all of the above information is true to the best of my knowledge.

SIGNATURE OF RETIREE	DATE	DAYTIME PHONE ()
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FOR CAMPUS/LAB USE ONLY

DATE RETIRED	LAST DAY ON PAY STATUS	DATE LAST PREMIUMS PAID AS EMPLOYEE: Medical:	Dental:	Legal:
		DATE PREMIUMS BEGAN AS RETIREE: Medical:	Dental:	Legal:
SIGNATURE OF BENEFITS REPRESENTATIVE		SUBJECT TO GRADUATED ELIGIBILITY (hired or rehired after 1/1/90)?		<input type="checkbox"/> YES <input type="checkbox"/> NO
		IF YES, INDICATE LATEST UCRP ENTRY DATE:		ESTIMATED YEARS SERVICE CREDIT:

FOR UC HR/BENEFITS USE ONLY

REMARKS: _____ DATE COMPLETED BY UC HR/BENEFITS: _____ EFFECTIVE DATE: _____

WHITE: UC HR/BENEFITS
CANARY: UC HR/BENEFITS
PINK: RETIREE COPY

SEE REVERSE FOR PRIVACY NOTIFICATIONS

PARTICIPATION TERMS AND CONDITIONS

Your Social Security number will be requested only as needed by benefit plan administration for financial reporting and to verify your identity, in compliance with state and federal law.

If you participate in UC-sponsored plans, you agree to the following terms and conditions:

1. **Most of the medical plans that UC offers (including the Blue Cross of California plans, Health Net, Kaiser Permanente, PacifiCare, Western Health Advantage, Definity Health, UnitedHealthcare plans, and PacifiCare Behavioral Health), as well as the PMI dental plan, require resolution of medical malpractice and other disputes through binding arbitration. When you enroll in these plans, you agree that any dispute between you (and/or your enrolled family members) and the medical or dental plan must be submitted to binding arbitration. You agree to waive your right to a jury or court trial to resolve these disputes.**

For more information about each plan's arbitration provision, please see the appropriate plan booklet or call the plan.

2. You acknowledge and accept all terms and conditions of the UC-sponsored plans in which you are enrolled as stated in the plan booklets and UC's Group Insurance Regulations.
3. If you enroll family members, the University and/or carrier may require proof of eligibility. Marriage or birth certificates, adoption papers, tax records, and the like may be requested. You agree to provide such documentation upon request.
4. If you enroll your eligible domestic partner and/or your partner's eligible child(ren) or grandchild(ren), you acknowledge that the UC/employer contribution for their medical and/or dental coverage may be considered your taxable income, subject to FICA (Social Security and Medicare) and federal and California state income tax withholding.
5. If you specifically ask UC representatives to intercede on your behalf with your insurance plan, you authorize the plan to release to the UC representatives pertinent health and personal information concerning you and/or your family member(s). University representatives will request and utilize only the minimum necessary health information required to assist you with your problem.

In compliance with state privacy laws and federal laws, including HIPAA (Health Insurance and Portability Act of 1996), in some instances you may be required to sign an authorization allowing UC to provide the insurance plan with relevant personal health information or authorizing the insurance plan to release such information to the University representative.
6. You authorize deductions from your earnings to cover your monthly costs, if any, for the plans you have chosen for yourself and your eligible family members.
7. Actions you take during Open Enrollment will be effective the following January 1, unless otherwise stated.

8. You certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in the *UC Group Insurance Eligibility Factsheet*. You agree that you will reenroll them within 31 days if they lose eligibility. You further certify that all the information you provide is true to the best of your knowledge, under penalty of perjury.
9. Making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility within 31 days, or failing to provide documentation when requested will lead to disenrollment of the family members and possible legal action. In addition, employees/retirees will be subject to disciplinary action (e.g., loss of health benefits for up to 18 months) and will be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage.

CONTINUATION PRIVILEGES

For legal spouse, natural or adopted child, stepchild, legal ward, other child, and/or grandchild

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued plan coverage for a certain period of time at specified monthly rates if you or your eligible family members lose group health coverage because you die, divorce, or are legally separated, or because a child ceases to be eligible. Call the UC Customer Service Center (1-800-888-8267) for more information.

For domestic partner, partner's child/grandchild, adult dependent relative*

While not required under COBRA, UC's health carriers have agreed to provide continuation coverage for an eligible adult dependent relative enrolled by 12/31/03, a domestic partner, or a partner's child/grandchild. Coverage may continue for a certain period of time at specified monthly rates if you or your eligible family members lose group medical or dental coverage because you die, because your relationship with an adult dependent relative or a domestic partnership ends, or because an adult dependent relative or a partner's child/grandchild is no longer eligible for coverage. Call the UC Customer Service Center (1 800-888-8267) for more information.

WHEN ELIGIBILITY ENDS

For domestic partner, partner's child/grandchild, adult dependent relative*

UC-sponsored group insurance coverage stops at the end of the month the dependent is no longer eligible. **UC requires the retiree to provide the adult dependent relative or the domestic partner with a copy of this cancellation form.** For medical and dental plan continuation coverage, the adult dependent relative or domestic partner should call the UC Customer Service Center (1-800-888-8267).

* An adult dependent relative is eligible to continue UC-sponsored coverage if enrolled by December 31, 2003, and coverage is continuous. Your adult dependent relative must not be eligible for Medicare Part A.

PRIVACY NOTIFICATIONS

STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting the information on this form is for payment of earnings and for miscellaneous payroll and personnel matters, such as, but not limited to, withholding taxes, benefits administration, and changes in title and pay status. University policy and state and federal statutes authorize the maintenance of this information.

Furnishing all information requested on this form is mandatory—failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be used by various University departments for payroll and personnel administration, and will be transmitted to the federal and state governments as required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from campus or Office of the President Staff and Academic Personnel Offices.

The official responsible for maintaining the information contained on this form is the Associate Vice President—University of California Human Resources and Benefits, 1111 Franklin Street, Oakland, CA 94607-5200.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. Disclosure of the Social Security number is required pursuant to sections 6011 and 6051 of Subtitle F of the Internal Revenue Code and with Regulation 4, Section 404.1256, Code of Federal Regulations under Section 218, Title II of the Social Security Act, as amended. The Social Security number is used to verify your identity. The principal uses of the number shall be to report (1) state and federal income taxes withheld, (2) Social Security contributions, (3) state unemployment and Workers' Compensation earnings, (4) earnings and contributions to participating retirement systems, and (5) as an identifier for your insurance carrier to verify your eligibility and to maintain claim records for you and your eligible family members.