

# COBRA CONTINUATION OPEN ENROLLMENT AND CHANGE FORM

UBEN 108 (R10/08) University of California Human Resources and Benefits

Note: This is not a COBRA application form. To apply for COBRA, employees should call their Benefits Office and retirees should call the UC Customer Service Center (1-800-888-8267).

## COMPLETING THIS FORM

### Section 1—Personal Information

Complete all the boxes in this section.

### Section 2—Type of Action

Check the reason you are completing the form. Be sure to include the date of the original COBRA qualifying event.

Qualifying events are certain events that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA.

### Section 3—Enroll/Transfer/Cancel Information

Complete this section if:

- You want to enroll in wellness, medical (including behavioral health), dental, and/or vision during Open Enrollment (see “Open Enrollment Reminders,” below).
- You want to change your medical and/or or dental plan during Open Enrollment.
- You are moving outside of your medical or dental plan’s service area and need to transfer into a different plan.

#### Open Enrollment Reminders

- For Open Enrollment information (generally held in November), visit At Your Service, the UC HR/Benefits website ([atyourservice.ucop.edu](http://atyourservice.ucop.edu)), or call the UC Customer Service Center (1-800-888-8267).
- You may enroll in another program (wellness, medical, dental, vision plan) during Open Enrollment if:
  - you were eligible for that program at the time of your original qualifying event, and
  - you elected COBRA continuation coverage for at least one of the health programs (medical, dental, vision) at that time and have been continuously enrolled, and
  - you will still be within your maximum COBRA continuation coverage period on January 1.
- If you change plans during Open Enrollment, or you enroll in another program, the new health plan carrier must receive this form by the Open Enrollment deadline.
- Changes made during Open Enrollment do not alter the length of COBRA continuation coverage.
- Open Enrollment changes and enrollments will be effective on the announced date (usually the following January 1).

### Section 4—Eligible Family Member(s)

Complete this section:

- To add a newly acquired dependent.
- To list the family members that should be covered under the wellness, medical, dental, or vision program into which you are enrolling.
- To list the family members that should be covered under the medical or dental plan into which you are transferring.

If you enroll in a medical plan which requires you to select a Primary Care Physician (PCP) or medical group and you do not select one, one will be selected for you.

### Section 5—Signature

Please sign and date the form.

## SUBMITTING THE FORM

Photocopy the completed form and send to the appropriate health plan carrier(s). If you are enrolling in another program, or you are transferring to a different medical or dental plan, send a copy to the new plan. Carrier mailing addresses and monthly premium information is available on the UC HR/Benefits website ([atyourservice.ucop.edu](http://atyourservice.ucop.edu)) or from the UC Customer Service Center (1-800-888-8267).

Keep a copy of the form for your records.

## FOR MORE INFORMATION

For complete information about COBRA continuation coverage and other continuation options, see the UC HR/Benefits website ([atyourservice.ucop.edu](http://atyourservice.ucop.edu)).

Note: COBRA continuation rights are subject to governing laws and regulations.

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Send a photocopy of the completed form to the appropriate health plan carrier(s) and keep a copy for your records. See cover sheet for details.

COBRA participants should use this form in order to make any of the changes listed under Section 2.

<b>1. PERSONAL INFORMATION</b>	
NAME OF COBRA PARTICIPANT (Last, First, Middle Initial)	DAYTIME PHONE ( )
MAILING ADDRESS (Number, Street, City, State, ZIP)	SEX <input type="checkbox"/> M <input type="checkbox"/> F
NAME OF EMPLOYEE/RETIREE (Last, First, Middle Initial)	EMPLOYEE/RETIREE SOCIAL SECURITY NUMBER
	CAMPUS/LAB
	HIRE DATE OF EMPLOYEE/RETIREE

<b>2. TYPE OF ACTION</b>		DATE OF ORIGINAL COBRA QUALIFYING EVENT
<b>Open Enrollment</b> <input type="checkbox"/> Enroll in wellness, medical, dental, or vision (also complete Sections 3 and 4) <input type="checkbox"/> Change medical or dental plan (also complete Sections 3 and 4)		
<b>Other</b> <input type="checkbox"/> Change medical or dental plan due to move outside plan's service area (also complete Sections 3 and 4) <input type="checkbox"/> Add newly acquired dependent (also complete Section 4) Date acquired: _____ <input type="checkbox"/> Delete dependent(s) from plans checked at right: <input type="checkbox"/> Wellness <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Name: _____ (Last, First, Middle Initial)	Name: _____ (Last, First, Middle Initial)	

<b>3. ENROLL/TRANSFER INFORMATION (Also complete Section 4 if appropriate)</b>	
ENROLL IN OR TRANSFER INTO THIS PLAN	UC GROUP POLICY NO. OF NEW PLAN (if applicable)
WELLNESS PROGRAM (STAYWELL)	
MEDICAL PLAN NAME	
DENTAL PLAN NAME	
VISION PLAN (VSP)	0101923

**4. ELIGIBLE FAMILY MEMBERS (Applicant or family member must complete this section.)**

If you are changing your medical or dental plan, or enrolling in wellness, medical, dental, or vision, list all eligible family members (including yourself) who should be covered under the plan(s). Attach separate sheet if necessary. If you are adding a newly acquired dependent, include information about this new dependent only. Enter the appropriate relationship codes. See codes below.

Last Name	First Name	Middle Initial	Check if Current Physician	Sex	Birthdate	Relationship*	Add Dependent to my Current Plan(s). Check Appropriate Box(es).	Social Security Number
				M <input type="checkbox"/> F <input type="checkbox"/>	MO DY YR 	Enter Code:	WELLNESS MEDICAL DENTAL VISION <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
PRIMARY CARE PHYSICIAN OR MEDICAL GROUP I.D. (APPLIES TO MEDICAL ONLY)								
				M <input type="checkbox"/> F <input type="checkbox"/>	MO DY YR 	Enter Code:	WELLNESS MEDICAL DENTAL VISION <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
PRIMARY CARE PHYSICIAN OR MEDICAL GROUP I.D. (APPLIES TO MEDICAL ONLY)								
				M <input type="checkbox"/> F <input type="checkbox"/>	MO DY YR 	Enter Code:	WELLNESS MEDICAL DENTAL VISION <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
PRIMARY CARE PHYSICIAN OR MEDICAL GROUP I.D. (APPLIES TO MEDICAL ONLY)								

\*RELATIONSHIP: 1 = Self 2 = Spouse 3 = Natural/Adopted Child 4 = Stepchild 5 = Legal Ward 6 = Other Child (enrolled before 9/1/94) 7 = Grandchild/Step-grandchild 8 = Domestic Partner (same-sex/opposite sex) 9 = Domestic Partner's Child/Grandchild 10 = Adult Dependent Relative (enrolled before 1/1/04)

<b>5. SIGNATURE</b>	
I certify that the information above is correct and I have read the Terms and Conditions on the following page. If I am enrolling in another program (wellness, medical, dental, or vision) during Open Enrollment, I certify that I meet the requirements noted on cover sheet under "Open Enrollment Reminders."	
COBRA PARTICIPANT	DATE

SEE REVERSE FOR PRIVACY NOTIFICATIONS

## TERMS AND CONDITIONS

By signing this form I agree to the following terms and conditions:

If I enroll family members, I certify that they are eligible for coverage based on the definitions and rules specified in the UC Group Insurance Regulations. I understand that UC and/or the various insurance carriers may require proof of eligibility. Marriage or birth certificates, adoption papers, tax records, and the like may be requested. I agree to provide such documentation upon request. I understand that if I do not, my family member(s) will be de-enrolled retroactively and I will be liable for all costs incurred in connection with the invalid enrollment.

Most of the medical plans that UC offers [including the medical portion of Anthem Blue Cross PLUS and Anthem Blue Cross PPO‡, Health Net, Western Health Advantage, and CIGNA Choice Fund], Core and High Option Supplement to Medicare (offered by Anthem Blue Cross Life and Health Insurance Company)‡, and Kaiser Permanente—CA require resolution of disputes through arbitration. With regard to each plan, *it is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under the 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 the 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.* For more information about each plan's arbitration provision, please see the appropriate plan booklet or call the plan.

## PREMIUMS

If you elect COBRA continuation, you will make the applicable monthly premium payments directly to the health plan carrier(s). Payments are due by the 10th of the month before the premium month—e.g., the June premium is due by May 10. The University will not contribute toward the cost of your group health coverage under COBRA continuation. Premiums are subject to change at least once a year, usually January 1.

## BENEFITS

Your coverage under COBRA continuation will be the same as it is under your current UC-sponsored plan(s). If the group coverage changes, your coverage will change correspondingly. At the end of your COBRA continuation period, you may be able to convert your medical coverage to an individual, direct-pay policy. You may not convert your wellness, dental or vision plan.

‡ Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association.

## 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 information on this form, including your Social Security number, is to verify your identity, and/or for benefits administration, and/or for federal and state income tax reporting. 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 transmitted to the federal and state governments when 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. The University's record keeping system was established prior to January 1, 1975 under the authority of The Regents of the University of California under Article 1X, Section 9 of the California Constitution. The principal uses of your Social Security number shall be for state tax and federal income tax (under Internal Revenue Code sections 6011.6051 and 6059) reporting, and/or for benefits administration, and/or to verify your identity.