

NOTICE TO UC OF A COBRA QUALIFYING EVENT

UBEN 109 (R7/07) University of California Human Resources and Benefits

Please photocopy this form for your records.

For certain types of COBRA qualifying events, you must submit notification to UC in writing within 60 days of the date of the qualifying event or the date coverage is lost as a result of the qualifying event, whichever is later.

Use this form to notify UC of the occurrence of any of the qualifying events shown below and to request a COBRA application packet.

- Divorce/legal separation/annulment
- Termination of domestic partnership
- Dependent's loss of eligibility

Note: Failure to provide notice of these events within the 60-day time limit will result in COBRA continuation coverage being forfeited.

Detailed information about COBRA continuation coverage is available on At Your Service, the UC HR/Benefits website (atyourservice.ucop.edu).

Only **qualified beneficiaries** can elect COBRA continuation coverage. A qualified beneficiary is generally a UC employee, retiree, or family member who is eligible for and enrolled in a UC-sponsored group health plan on the day before the qualifying event.

Employees: Complete this notice and submit it to your Benefits Office or the person in your department who handles benefits within the 60-day period mentioned above. Upon receipt of this notice, your Benefits Office or department will send you a COBRA application packet. You must also submit an *Enrollment, Change, Cancellation, or Opt Out* form (UPAY 850; available on the HR/Benefits website (atyourservice.ucop.edu)) in order to delete your ineligible family member(s) from your health plans. (The UPAY 850 form is not necessary when a child is reaching age 23 because de-enrollment is automatic.)

Retirees: Complete this notice and submit it to the UC Customer Service Center (P.O. Box 24570, Oakland, CA 94623-1570) within the 60-day period mentioned above. Upon receipt of this notice, the UC Customer Service Center will send you a COBRA application packet. You must also submit a *Retiree Continuation, Enrollment, or Change* form (UBEN 100) in order to delete your ineligible family members from your health plans. (The UBEN 100 form is not necessary when a child is reaching age 23 because de-enrollment is automatic.) This form is available on the UC HR/Benefits website (atyourservice.ucop.edu) or from the UC Customer Service Center (1-800-888-8267).

1. PERSONAL INFORMATION

NAME OF EMPLOYEE/RETIREE (Last, First, Middle Initial)

UC EMPLOYEE

UC RETIREE

DAYTIME PHONE

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EMPLOYEE ID#/RETIREE SOCIAL SECURITY NUMBER

CAMPUS/LAB

NAME OF QUALIFIED BENEFICIARY REQUESTING A COBRA APPLICATION PACKET (Last, First, Middle Initial)

MAILING ADDRESS TO WHICH COBRA PACKET SHOULD BE SENT (Number, Street, City, State, ZIP)

Attach a separate sheet if more than one address.

2. TYPE OF QUALIFYING EVENT/DATE OF QUALIFYING EVENT

Indicate the type of COBRA qualifying event:

Divorce/legal separation/annulment

Child's or grandchild's loss of eligibility

Termination of domestic partnership

Domestic partner's child's/grandchild's loss of eligibility

Adult dependent relative's loss of eligibility

Date of Qualifying Event:

____ | ____ | ____
Mo Dy Yr

3. SIGNATURE

I certify that the information on this form is true and correct.

NAME OF THE PERSON NOTIFYING UC OF QUALIFYING EVENT

RELATIONSHIP TO EMPLOYEE/RETIREE

SIGNATURE

DAYTIME PHONE

DATE

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RETN: Five years at office of record.

SEE NEXT PAGE FOR PRIVACY NOTIFICATIONS

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.