

ENROLLMENT, CHANGE, CANCELLATION, OR OPT OUT—EMPLOYEES ONLY

HEALTH AND WELFARE PLANS

UPAY 850 (R10/04) University of California Human Resources and Benefits

Use this form to enroll in, change, cancel, or opt out of insurance plans for yourself and/or your eligible family members. For complete information on eligibility, effective dates, and allowable actions, see *Your Group Insurance Plans*, available on the At Your Service website (<http://atyourservice.ucop.edu>) or from your department or Benefits Office.

If the only action you require is to enroll or cancel coverage for a family member*, you must complete Sections 1, 2, and 5. List only the eligible family member(s) you wish to enroll or de-enroll, or for whom you are changing personal data. Current enrollments will remain in effect until you notify UC of a change, subject to payroll deadlines. If you are changing plans, complete Sections 1 and 3 only; your enrolled family members will change plans automatically. Please note that you may only enroll your eligible family members in the plans in which you are enrolled.

To name your beneficiaries for the Supplemental Life and AD&D plans, go online (<http://atyourservice.ucop.edu>) or use form UBEN 716. You are automatically the beneficiary of a family member under your Expanded Dependent Life and/or AD&D insurance plans. To designate a different beneficiary, use form UBEN 119.

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 and Accountability 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 de-enroll 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 de-enrollment 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 monthly rates if you or your eligible family members lose group medical, dental, or vision coverage because you die, divorce, or are legally separated, or because a child ceases to be eligible. Call your Benefits Office for more information.

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

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

WHEN ELIGIBILITY ENDS

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

UC-sponsored group insurance coverage stops at the end of the month the dependent is no longer eligible. **UC requires the employee to provide the domestic partner or the adult dependent relative with a copy of this cancellation form.** For medical, dental, or vision plan continuation coverage, the domestic partner or adult dependent relative should call the employee's Benefits Office.

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

HIPAA (Health Insurance Portability and Accountability Act of 1996) Notification of Medical Program Eligibility

You may decline enrollment for yourself and/or your eligible family members (including your spouse) because you have other group medical insurance coverage. If you lose that coverage in the future, you may be able to enroll yourself and/or your eligible family members in a UC-sponsored medical plan. You must request enrollment within 31 days after the other coverage ends.

If you are enrolled in a UC-sponsored medical plan, and you have a newly eligible family member as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll your eligible family member(s). You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you do not enroll your eligible family member(s) within the 31 days when first eligible, you may enroll in medical plan coverage only at a later date. However, they will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective; or you can enroll them during the next Open Enrollment period.

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. (A)

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 officials responsible for maintaining the information contained on this form are Office of the President and campus Academic and Staff Personnel Managers or campus Accounting Officers.

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. (AA)

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If you have enrolled online using the At Your Service website, do not use this form.

It is your responsibility to submit this form to the appropriate office for processing. Submit this form to your Benefits or Accounting Office or to the person handling benefits for your department. Shaded areas should be completed by the person updating the online system.

1. PERSONAL INFORMATION				
NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	CAMPUS/LAB AND DEPARTMENT	CAMPUS/LAB PHONE ()	EMPLOYEE I.D. NO.
HOME ADDRESS (Number, Street, City, State, ZIP)				HOME PHONE ()

2. EMPLOYEE ACTIONS		
TYPE OF ACTION OR QUALIFYING EVENT (check all that apply): <input type="checkbox"/> New hire (date: _____) <input type="checkbox"/> Rehire (date: _____) <input type="checkbox"/> Open Enrollment (effective 01/01/05) Add eligible family member: <input type="checkbox"/> Spouse (date of marriage: _____) <input type="checkbox"/> Domestic partner (refer to <i>Your Group Insurance Plans</i> for definition): ___ Registered with the State of California (filing date: _____) ___ Not registered with the State of California. I certify I can provide the required documentation to verify eligibility. (date partnership began: _____) <input type="checkbox"/> Other eligible family member (explain in comments box below)	WRITE IN DATE OF EVENT, if applicable. <input type="checkbox"/> Cancel coverage indicated below (date: _____) <input type="checkbox"/> Delete family member (date: _____) Reason: ___ Divorce, legal separation, annulment ___ Termination of partnership registered with the State of California (filing date of termination: _____) ___ Termination of partnership not registered with the State of California (date relationship ended: _____) ___ Loss of eligibility for adult dependent relative ___ Loss of eligibility for dependent child status ___ Other (provide reason in comments box below) <input type="checkbox"/> Change in appointment status (date: _____) <input type="checkbox"/> Change personal data for eligible family member (date: _____) <input type="checkbox"/> Inter-campus transfer (previous location: _____)	<input type="checkbox"/> Move out of/return to plan's service area (date: _____) <input type="checkbox"/> Statement of Health <input type="checkbox"/> Cancel previous opt out request <input type="checkbox"/> Involuntary loss of coverage (date: _____) (Please attach a letter from the employer certifying that you and your family member(s) were enrolled in the plan(s) and specifying the date coverage ends.) <input type="checkbox"/> Begin leave/furlough (date: _____) <input type="checkbox"/> Return from leave/furlough (date: _____) <input type="checkbox"/> Other (specify: _____) (e.g., HIPAA 90-day delayed effective date) <input type="checkbox"/> Opt out of the Tax Savings on Insurance Premiums (TIP) <input type="checkbox"/> Re-enroll in the Tax Savings on Insurance Premiums (TIP)
Comments:		

2A. OPT OUT OF UNIVERSITY-SPONSORED COVERAGE	
I wish to decline coverage under the following University-sponsored plans: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	I am declining this coverage because (check one): <input type="checkbox"/> I am currently covered as an eligible family member or retiree under a University-sponsored plan(s). Covered participant's Social Security No.: _____ <input type="checkbox"/> I am currently covered under a non-UC-sponsored group plan(s) of religious beliefs. I understand that if I opt out of UC-sponsored medical, dental, or vision coverage, UC will not provide me or my family members with coverage.

3. MEDICAL, DENTAL, VISION, AND LEGAL			
To enroll in any of the plans listed below, mark the "Enroll" box. To change a plan, mark the "Cancel" box for your existing plan and mark the "Enroll" box for your new plan. If you cancel coverage for yourself, your enrolled family members will also be de-enrolled.			
MEDICAL Health Net ¹ <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel Kaiser—CA ¹ <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel PacifiCare—CA ¹ <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel Western Health Advantage ¹ <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel Core <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel Blue Cross PLUS ¹ <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel Blue Cross PPO <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel UnitedHealthcare Select EPO <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel Definity Health ² <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel Other: _____ <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	DENTAL Delta Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel PMI <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	VISION Vision Service Plan (VSP) <input type="checkbox"/> Enroll (You may not cancel vision coverage, due to internal procedures. However, you may opt out of vision coverage; see 2A, above.)	LEGAL ARAG Legal Plan <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel (Available during announced Open Enrollment periods and during your Period of Initial Eligibility.) Adult Dependent Relatives may not enroll in the Legal Plan.

4. OTHER INSURANCE PLANS—SEE FORM INTRODUCTION FOR INFORMATION ON NAMING BENEFICIARIES FOR LIFE INSURANCE AND AD&D PLANS			
Employee only SUPPLEMENTAL DISABILITY <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change Waiting Period (Check one): <input type="checkbox"/> 7 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days WAITING PERIOD: Your Short-Term Disability waiting period will be the same as the Supplemental Disability waiting period you select. (NOTE: You must also submit a Statement of Health to decrease your waiting period.)	SUPPLEMENTAL LIFE <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change (Check one): <input type="checkbox"/> 1 Times Annual Salary <input type="checkbox"/> 2 Times Annual Salary <input type="checkbox"/> 3 Times Annual Salary <input type="checkbox"/> 4 Times Annual Salary <input type="checkbox"/> Flat Amount (\$20,000) (NOTE: You may be required to submit a Statement of Health to increase your coverage level.)	Employee and/or eligible family members DEPENDENT LIFE <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change (Check one): <input type="checkbox"/> Basic Plan (spouse/domestic partner and children, as applicable) <input type="checkbox"/> Expanded Plan (select type of coverage) <input type="checkbox"/> Spouse/Domestic Partner Only <input type="checkbox"/> Spouse/Domestic Partner and Child(ren) <input type="checkbox"/> Child(ren) Only	ACCIDENTAL DEATH & DISMEMBERMENT <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change (Check one): <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Modified Family COVERAGE AMOUNT (Check One): <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$175,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$400,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$150,000

5. ELIGIBLE FAMILY MEMBER ACTIONS												
Complete this section to: (1) enroll or de-enroll an eligible family member in the medical, dental, vision, and/or legal plans or (2) change personal data (e.g., correct a misspelled name or provide a Social Security number). Also check the appropriate box in Section 2. In the Action box, circle "E" for enroll or "D" for de-enroll, and check the appropriate insurance plan box. If you are enrolling or de-enrolling family members, show the date of the event (marriage, birth, adoption, divorce, death, or domestic partnership or termination of partnership). If you enroll in a plan which requires a Primary Care Physician (PCP) or medical group and do not select one, one will be selected for you.												
Relationship Codes: Enter the appropriate code to indicate the family member's relationship to you.												
Action	Date of Event	Name (Last, First, MI)	Sex	Relationship (use codes)	Birthdate	Social Security number	Med	Dent	Vis	Leg	Primary Care Physician or Medical Group I.D.	Check if Current Physician
ADULTS —You may only enroll one eligible adult other than yourself: Legal Spouse (S), Same-Sex Domestic Partner (D), or Opposite-Sex Domestic Partner (L). Adult Dependent Relatives (A) may not enroll after 12/31/03 (see note on reverse).												
Circle E or D	MO DY YR	LISTED IN SECTION 1		SELF	MO DY YR	LISTED IN SECTION 1					LISTED IN SECTION 3	Name _____ ID No: _____
E D	MO DY YR	1.			MO DY YR	REQUIRED FOR (S) (D)						Name _____ ID No: _____
CHILDREN —Enter the appropriate code to indicate the family member's relationship to you: Child (Natural/adopted) (C), Partner's child/grandchild (K), Stepchild (P), Legal ward (W), Grandchild (G), Other child (enrolled before 9/1/94) (O), Non-tax dependent overage disabled child (N).												
E D	MO DY YR	3.			MO DY YR							Name _____ ID No: _____
E D	MO DY YR	4.			MO DY YR							Name _____ ID No: _____
E D	MO DY YR	5.			MO DY YR							Name _____ ID No: _____
E D	MO DY YR	6.			MO DY YR							Name _____ ID No: _____

My signature below indicates I have read and agree to the "Terms and Conditions" on the back of this form. I declare under penalty of perjury that all of the above information is true to the best of my knowledge.

EMPLOYEE'S SIGNATURE	DATE	SYSTEM UPDATED BY	DATE
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