

# DEPCARE/HCRA ENROLLMENT, CHANGE, OR CANCELLATION SALARY REDUCTION AGREEMENT

UPAY 919 (5/05) University of California Human Resources and Benefits

Fill in all the pertinent information. Shaded areas are for accounting use only. Send this form to your Accounting or Benefits Office or to the person handling benefits for your departments.

## Form Instructions:

This form pertains to the Health Care Reimbursement Account (HCRA) and/or the Dependent Care Reimbursement Account (DepCare) programs. Use this form to: Enroll due to an eligible mid-year status event, re-enroll in either plan during this calendar year, cancel your coverage, change your contribution, transfer between UC locations, or re-enroll in the same plan during the calendar year. Note that the effective date for HCRA and DepCare is different from other plans. For additional information regarding coverage effective dates, contact your Benefits Office or the person in your department who handles benefits.

To enroll in HCRA or DepCare because you are a newly hired or rehired, or because you are hired into an appointment making you eligible for the plan, use form UPAY 717 (*DepCare/HCRA Enrollment Salary Reduction Agreement*). Note: you may only use this form if you are enrolling in the plan for the first time this calendar year.

### Abbreviations and definitions used in this form:

<b>Break in coverage:</b>	A continuous period of time during which you are de-enrolled during a plan year
<b>Dependent:</b>	Refer to the HCRA and DepCare Summary Plan Descriptions for definition of dependent under each of these plans
<b>FML:</b>	Family medical leave as defined under the Federal Family and Medical Leave Act (FMLA)
<b>FSA:</b>	Flexible Spending Account
<b>Health plan:</b>	Medical, dental or vision plan
<b>PIE:</b>	Period of initial eligibility
<b>Spouse:</b>	Your legal spouse

Enter the appropriate code in section 2B on the following page (for example: B-1 if you gain an eligible dependent)

HCRA ELIGIBLE MID-YEAR STATUS EVENTS	
Code	CHANGE IN MARITAL STATUS
A-1	marriage
A-2	marriage, and you or your dependent becomes eligible under and enrolls in your spouse's own employer's health plan, or your spouse is enrolled in his/her own employer's health FSA
A-3	death of your spouse or divorce/legal separation/annulment
A-4	death of your spouse or divorce/legal separation/annulment and you or your dependent loses coverage under your spouse's own employer's health plan or health FSA
Code	GAIN OR LOSS OF A DEPENDENT
B-1	you gain an eligible dependent (for example, through birth or adoption, or a child moves in with you)
B-2	death of your dependent or your dependent is no longer financially supported by you
Code	CHANGE IN EMPLOYMENT STATUS
C-1	you, your spouse or dependent gains eligibility for and enrolls in own employer's health FSA or enrolls in own employer's health plan because you/he/she starts employment or has an employment status change
C-2	you, your spouse or dependent loses eligibility for own employer's health FSA or health plan because you/he/she ends employment or has an employment status change

Enter the appropriate code in section 2B on the following page (for example: D-1 for an increase in provider's cost)

DEPCARE ELIGIBLE MID-YEAR STATUS, PROVIDER AND COST CHANGE EVENTS	
Code	CHANGE IN MARITAL STATUS
A-1	marriage, and you acquire a dependent as a result
A-2	marriage, and your spouse is either not employed, or is enrolled in his/her own employer's dependent care FSA
A-3	death of your spouse or divorce/legal separation/annulment, and your spouse was enrolled in his/her own employer's dependent care FSA
Code	GAIN OR LOSS OF A DEPENDENT
B-1	you gain an eligible dependent (for example, through birth or adoption, or a spouse becomes incapable of self-care)
B-2	you lose an eligible dependent (for example, through death, or your child becomes 13 and is no longer eligible)
Code	CHANGE IN EMPLOYMENT STATUS
C-1	you or your spouse becomes eligible under and enrolled in his/her employer's dependent care FSA due to starting employment or to a change in employment status
C-2	you or your spouse loses eligibility under your/his/her employer's dependent care FSA due to ending employment or to a change in employment status
Code	COST CHANGE (does not apply if provider is your relative by blood or marriage)
D-1	there is an increase in provider's cost
D-2	there is a decrease in provider's cost
Code	CHANGE IN PROVIDER OR COVERAGE
E-1	there is a change in provider
E-2	there is a reduction in hours of care, or cessation of care
E-3	there is a change (in whole or part) from paid to free care or vice versa
E-4	your spouse starts working
E-5	your spouse stops working
E-6	you or your spouse changes work schedule and this creates, changes or eliminates need for care
E-7	your spouse is not working or looking for work and becomes a full-time student or becomes incapable of self-care
E-8	your spouse is not working or looking for work and is no longer a full-time student or is no longer incapable of self-care

# DEPCARE/HCRA ENROLLMENT, CHANGE, OR CANCELLATION SALARY REDUCTION AGREEMENT

UPAY 919 (5/05) University of California Human Resources and Benefits

Fill in all the pertinent information. Shaded areas are for accounting use only. Send this form to your Accounting or Benefits Office or to the person handling benefits for your department.

**For a Period of Initial Eligibility (PIE) enrollment or change action: Fill out sections 1, 2A, 2B (use codes on instructions page), 3A (if applicable) and 4. To cancel coverage: Fill out sections 1, 2A, 2B (use codes on cover page), and 4. Effective date for cancellation: end of the month following the month the last deduction is taken.**

**If you are in HCRA and going on a family medical leave: Fill out sections 1, 3B, and 4.**

## 1. PERSONAL INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)		SOCIAL SECURITY NUMBER			EMPLOYEE ID NUMBER		
LOCATION	CAMPUS/LAB PHONE ( )	BIRTHDATE MO   DY   YR	COVERAGE EFFECTIVE DATE MO   DY   YR		HIRE DATE MO   DY   YR		

## 2A. TYPE OF EVENT Effective date for Change or PIE enrollment actions: first of the month following the date the data on this form is processed.

Change   
  Cancellation   
  **PIE Enrollment (When you are enrolling due to an eligible mid-year event or when you are re-enrolling in the same plan(s) this calendar year)**

Interlocation transfer from \_\_\_\_\_ to \_\_\_\_\_ (MO/DY/YR \_\_\_\_\_)

## 2B. TYPE OF EVENT: Check the type and enter the date of the event

Rehire (MO/DY/YR \_\_\_\_\_)                     
  Change in appointment status (MO/DY/YR \_\_\_\_\_)

Unpaid leave/furlough (MO/DY/YR \_\_\_\_\_)                     
  Return from unpaid leave/furlough (MO/DY/YR \_\_\_\_\_)

Eligible mid-year status, provider and cost change events: Changes permissible due to these events must be on account of and correspond with the event. Enter the code for the event that applies to you. Refer to the chart on the cover page.

HCRA: Code (for example, B-1): \_\_\_\_\_ (MO/DY/YR \_\_\_\_\_)   
 DepCare: Code (for example, E-2): \_\_\_\_\_ (MO/DY/YR \_\_\_\_\_)

## 3A. CONTRIBUTION ELECTION (Your monthly contribution will appear on your pay advice)

**I am making a contribution change due to an eligible mid-year status event and there is no break in coverage.**  
 New contribution amount: Reduce my gross salary by: HCRA \$ \_\_\_\_\_/year    DepCare \_\_\_\_\_/year.

**I am re-enrolling after a break in coverage of 120 days or more.**  
 New contribution amount: Reduce my gross salary by: HCRA \$ \_\_\_\_\_/year    DepCare \_\_\_\_\_/year.

**I am re-enrolling after a break in coverage of less than 120 days.** Your HCRA annual contribution or DepCare monthly contribution must be the same as your last contribution. Re-enroll in  HCRA  DepCare

## 3B. For HCRA only—Approved Family Medical Leave (FML) Check the action and enter the date of the event

During my Family Medical Leave (FML):  Cancel my coverage   
  Continue my coverage. Upon my return I will prorate the rest of my plan year total over the remaining months.

Date leave begins: \_\_\_\_\_ (MO/DY/YR)   
  Continue my coverage. Upon my return I will resume the same monthly contributions and my plan year total will be reduced by any contributions missed during my FML.

## 4. SIGNATURE

**My signature below indicates I have read and agree to the "Terms and Conditions" on this form. I certify under penalty of perjury that all of the above information is true to the best of my knowledge, and that I have experienced the event or cost change noted in 2B above.**

EMPLOYEE'S SIGNATURE	DATE
----------------------	------

FOR OFFICE USE ONLY				
Break in coverage of less than 120 days	LAST HCRA CONTRIBUTIONS	LAST DEPCARE CONTRIBUTIONS	NEW HCRA CONTRIBUTIONS	NEW DEPCARE CONTRIBUTIONS
ANNUAL	\$	\$	\$ (must be same as last contribution)	\$
MONTHLY	\$	\$	\$	\$ (must be same as last contribution)
<b>Break in coverage of 120 days or more /or no break</b>	LAST HCRA CONTRIBUTIONS	LAST DEPCARE CONTRIBUTIONS	NEW HCRA CONTRIBUTIONS	NEW DEPCARE CONTRIBUTIONS
ANNUAL	\$	\$	\$ (amount in 3A above)	\$ (amount in 3A above)
MONTHLY	\$	\$	\$	\$
SYSTEM UPDATED BY			DATE	

## 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.

### TERMS AND CONDITIONS

**By signing this form, you agree to the following terms and conditions:**

- 1. You understand and accept all terms and conditions for the UC-sponsored plans in which you are enrolled as stated in the plan booklets and UC's Group Insurance Regulations.**
- 2. When you specifically ask UC representatives to intercede on your behalf with your plan administrator, you authorize the administrator to release to the UC representatives the pertinent records pertaining to you and/or your family member(s). You also authorize UC to provide the administrator with any relevant personal health information (applies to HCRA only) necessary to resolve your inquiry.**
- 3. You authorize deductions from your earnings to cover your monthly contributions.**
- 4. Continued participation in HCRA and DepCare requires annual enrollment during Open Enrollment.**