

ENROLLMENT, CHANGE, CANCELLATION, OR OPT OUT—EMPLOYEES ONLY HEALTH AND WELFARE PLANS

UPAY 850 (R10/03) 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>), from your department, or Benefits Office.

If the only action you require is to enroll or to 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 disenroll, 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.

Use form UPAY 718 to name your beneficiaries for the Supplemental Life and AD&D plans. 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 UPAY 718A.

TERMS AND CONDITIONS

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

1. Most of the medical plans that UC offers (including Blue Cross of California plans, Health Net, Kaiser Permanente, PacifiCare, Western Health Advantage, Definity Health, the 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 give up 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 understand 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. You agree to provide such documentation upon request.
4. If you enroll your same-sex domestic partner and/or your partner's 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. When you specifically ask UC representatives to intercede on your behalf with your insurance plan, you authorize the plan to release to the UC representatives the appropriate records pertaining to you and/or your family member(s). For health plans you may be required to provide a signed authorization allowing the plan to release personal health information to the University representative. You also authorize UC to provide the insurance plan with any relevant personal health information.
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.
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 disenroll 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 may lead to disenrollment of the family members and to legal action. In addition, employees will be subject to disciplinary action (e.g., loss of health benefits for 18 months) and will be responsible for any employer contributions to and benefits paid by the plan.

PLEASE NOTE: Use of your Social Security number for benefit plan administration purposes complies with state and federal laws.

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 adult dependent relative, same-sex domestic partner, partner's child/grandchild

While not required under COBRA, UC's health carriers have agreed to provide continuation coverage for an eligible adult dependent relative, same-sex 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, dental, or vision coverage because you die, because your relationship with an adult dependent relative or a same-sex domestic partnership 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 adult dependent relative, same-sex domestic partner, partner's child/grandchild

UC-sponsored group insurance coverage stops at the end of the month in which an adult dependent relative, same-sex domestic partner, or a partner's child or grandchild is no longer eligible. **UC requires the employee to provide the adult dependent relative or the same-sex domestic partner with a copy of this cancellation form.** For medical, dental, and vision plan continuation coverage, the adult dependent relative or same-sex domestic partner 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. If you enroll an adult dependent relative, your legal spouse or your same-sex domestic partner will not be eligible for UC-sponsored medical, dental, vision, legal, dependent life, or accidental death and dismemberment (AD&D) coverage, or to continue coverage under COBRA.

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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HEALTH AND WELFARE PLANS

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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 AND DEPARTMENT	CAMPUS/LAB PHONE ()	EMPLOYEE I.D. NO.
HOME ADDRESS (Number, Street, City, State, ZIP)		CAMPUS/LAB EMAIL ADDRESS		HOME PHONE ()

2. EMPLOYEE ACTIONS

TYPE OF ACTION OR QUALIFYING EVENT (check all that apply): WRITE IN DATE OF EVENT, if applicable.

<input type="checkbox"/> New hire (date: _____)	<input type="checkbox"/> Change personal data for eligible family member (date: _____)	<input type="checkbox"/> Open Enrollment (effective 1/1/04)
<input type="checkbox"/> Rehire (date: _____)	<input type="checkbox"/> Inter-campus transfer (Attach copy of most recent paycheck from previous location.)	<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"/> Cancel coverage indicated below (date: _____)	<input type="checkbox"/> Move out of/return to plan's service area (date: _____)	<input type="checkbox"/> Begin leave/furlough (date: _____)
<input type="checkbox"/> Change in appointment status (date: _____)	<input type="checkbox"/> Statement of Health	<input type="checkbox"/> Return from leave/furlough (date: _____)
<input type="checkbox"/> Add eligible family member (date: _____)	<input type="checkbox"/> Cancel previous opt-out request	<input type="checkbox"/> Other (specify: _____) (e.g., HIPAA 90-day delayed effective date)
<input type="checkbox"/> Same-sex domestic partnership registered with the State of California (filing date: _____) If not registered, check "Add eligible family member" box above.		
<input type="checkbox"/> Delete family member (date: _____) Reason: <input type="checkbox"/> Divorce, legal separation, annulment <input type="checkbox"/> Termination of same-sex domestic partnership <input type="checkbox"/> Loss of eligibility for adult dependent relative <input type="checkbox"/> Loss of eligibility for dependent child status <input type="checkbox"/> Other (provide reason in comments box)	Comments:	

2A. OPT OUT OF UNIVERSITY-SPONSORED COVERAGE

I wish to decline coverage under the following University-sponsored plans:

Medical Dental Vision

I am declining this coverage because (check one):

I am currently covered as an eligible family member or annuitant under a University-sponsored plan(s). Covered participant's Social Security No.: _____

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 coverage, UC will not provide me or my family with medical, dental, or vision 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 disenrolled.

MEDICAL Health Net ¹ <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel Kaiser—CA ¹ <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel PacificCare—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 POS ¹ <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel Blue Cross PPO <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel UnitedHealthcare Select EPO OOA ¹ <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.
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¹ You must live in the plan's service area.
² Only available for UCSF and UCSB employees on or after 1/1/04.

4. OTHER INSURANCE PLANS—SEE REVERSE 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/same-sex domestic partner and children, as applicable) <input type="checkbox"/> Expanded Plan (select type of coverage) <input type="checkbox"/> Spouse/Same-sex Domestic Partner Only <input type="checkbox"/> Spouse/Same-sex 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"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$175,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$400,000 <input type="checkbox"/> \$500,000
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5. ELIGIBLE FAMILY MEMBER ACTIONS

Complete this section to: (1) enroll or disenroll 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 disenroll, and check the appropriate insurance plan box. If you are enrolling or disenrolling family members, show the date of the event (marriage, birth, adoption, divorce, death, or same-sex domestic partnership or termination of partnership).

Relationship Codes: Enter the appropriate code to indicate the family member's relationship to you. You may only enroll one adult other than yourself: Legal Spouse (S) or Same-Sex Domestic Partner (D). Adult Dependent Relative (A) may not enroll after 12/31/03. (See note on reverse.)

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												
Circle E or D below	MO DY YR	1. LISTED IN SECTION 1		SELF	MO DY YR	LISTED IN SECTION 1					LISTED IN SECTION 3	Name _____ ID No: _____
E D	MO DY YR	2.			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).												
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 certify 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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RETN: Accounting: 5 years following separation in cases involving disability retirement or disciplinary action, retain until age 70.
Other copies: 0-5 years after separation.

WHITE -BENEFITS OR ACCOUNTING
CANARY -MEDICAL CARRIER
PINK -EMPLOYEE

SEE REVERSE FOR PRIVACY NOTIFICATIONS