

RETIREE CONTINUATION, ENROLLMENT, OR CHANGE—MEDICAL, DENTAL AND/OR LEGAL PLAN
UBEN 100 (R10/11) University of California Human Resources

Mail completed form to: RASC—Retiree Insurance Program
 P.O. Box 24570
 Oakland, CA 94623-1570
 OR fax to: 510-987-9323

For help with this form, call the UC Customer Service Center (1-800-888-8267) or your location's Health Care Facilitator; for the contact list, visit:
 atyourservice.ucop.edu/directories_contacts/health_care_facilitator.html

1. PERSONAL INFORMATION—RETIREE, SURVIVOR OR DISABLED MEMBER

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	FORMER CAMPUS/LAB LOCATION	RETIREMENT SYSTEM COVERAGE <input type="checkbox"/> UCRP <input type="checkbox"/> CalPERS <input type="checkbox"/> OTHER (Specify):
ADDRESS (Number, Street)	(City, State, ZIP)	EMAIL ADDRESS	

2. ACTIONS Select plan(s) in Section 3.

<p>ENROLL (documentation upon request)</p> <input type="checkbox"/> Opposite-sex spouse (date of marriage: _____) <input type="checkbox"/> Same-sex spouse (date of marriage: _____) <input type="checkbox"/> Domestic partner: • Registered with State of CA (filing date: _____) • Not registered with State of CA. (date partnership began: _____) <input type="checkbox"/> Other eligible family member (effective date: _____) <input type="checkbox"/> New survivor (member date of death: _____) <input type="checkbox"/> Late enrollment—medical only (90-day delayed effective date: _____) <input type="checkbox"/> Involuntary loss of coverage (Loss of coverage date: _____) <input type="checkbox"/> Other (explain in comment box below)	<p>CANCEL</p> <input type="checkbox"/> Divorce, legal separation, annulment (date: _____) <input type="checkbox"/> Termination of domestic partnership (date: _____) <input type="checkbox"/> Death (date: _____) <input type="checkbox"/> Family member (effective date: _____) <input type="checkbox"/> Other (effective date: _____) <p>SUSPEND: (effective date: _____) <input type="checkbox"/> Medical plan due to other group/individual coverage <input type="checkbox"/> Medical plan due to TRICARE For Life <input type="checkbox"/> Dental plan due to other group/individual coverage</p>	<p>CHANGE</p> <input type="checkbox"/> Open Enrollment (effective January 1 of the following year) <input type="checkbox"/> Move out of/return to plan's service area (date: _____) <input type="checkbox"/> Medicare plan not available/provider group disruption <input type="checkbox"/> Transfer plans to retirement (retirement date: _____) <input type="checkbox"/> Transfer plans to UCRP disability <input type="checkbox"/> Other (explain in comment box below)
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Comments:

MEDICARE—Send UC a copy of the Medicare card(s) when you first enroll in Medicare.

Retiree					Retiree's Spouse or Domestic Partner or Child (circle)												
Effective Date	Medicare Part A:	MO	DY	YR	Medicare Part B:	MO	DY	YR	Effective Date	Medicare Part A:	MO	DY	YR	Medicare Part B:	MO	DY	YR
MEDICARE CLAIM NUMBER:									MEDICARE CLAIM NUMBER:								

3. MEDICAL, DENTAL, AND LEGAL To de-enroll from your current plan, check "cancel." If you are enrolled in a non-UC plan, check "suspend."

<p>MEDICAL PLAN</p> <table style="width:100%;"> <tr> <td style="width:33%;"> ENROLL CANCEL SUSPEND Anthem Blue Cross PLUS¹ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anthem Blue Cross PPO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Core <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </td> <td style="width:33%;"> ENROLL CANCEL SUSPEND Health Net¹ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Health Net Blue & Gold^{1,4} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kaiser-CA¹ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </td> <td style="width:33%;"> ENROLL CANCEL SUSPEND High Option Supplement to Medicare³ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Western Health Advantage^{1,2} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </td> </tr> </table>	ENROLL CANCEL SUSPEND Anthem Blue Cross PLUS ¹ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anthem Blue Cross PPO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Core <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	ENROLL CANCEL SUSPEND Health Net ¹ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Health Net Blue & Gold ^{1,4} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kaiser-CA ¹ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	ENROLL CANCEL SUSPEND High Option Supplement to Medicare ³ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Western Health Advantage ^{1,2} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>DENTAL PLAN</p> <table style="width:100%;"> <tr> <td style="width:33%;"> ENROLL CANCEL SUSPEND Delta Dental PPO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DeltaCare® USA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (Dental HMO; CA residents only) </td> <td style="width:33%;"> ENROLL CANCEL ARAG Legal Plan <input type="checkbox"/> <input type="checkbox"/> (Legal Plan is not open for enrollment during Open Enrollment every year.) </td> </tr> </table>	ENROLL CANCEL SUSPEND Delta Dental PPO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DeltaCare® USA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (Dental HMO; CA residents only)	ENROLL CANCEL ARAG Legal Plan <input type="checkbox"/> <input type="checkbox"/> (Legal Plan is not open for enrollment during Open Enrollment every year.)	
ENROLL CANCEL SUSPEND Anthem Blue Cross PLUS ¹ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anthem Blue Cross PPO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Core <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	ENROLL CANCEL SUSPEND Health Net ¹ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Health Net Blue & Gold ^{1,4} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kaiser-CA ¹ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	ENROLL CANCEL SUSPEND High Option Supplement to Medicare ³ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Western Health Advantage ^{1,2} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
ENROLL CANCEL SUSPEND Delta Dental PPO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DeltaCare® USA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (Dental HMO; CA residents only)	ENROLL CANCEL ARAG Legal Plan <input type="checkbox"/> <input type="checkbox"/> (Legal Plan is not open for enrollment during Open Enrollment every year.)						

1 Must live in plan's service area 2 Only non-Medicare 3 All enrollees must be enrolled in Medicare Parts A & B 4 One member must be non-Medicare

4. ENROLLEE INFORMATION List yourself and all eligible family members referred to in Section 2. In the Action box below, check "E" for enroll or "C" for cancel.

Enter the Relationship Code in box below: **You may only enroll one adult other than yourself.** (Codes D, L, and K may be subject to imputed income unless tax dependent of retiree for federal purposes.)
Eligible adult: S – Opposite-sex spouse D – Same-sex spouse or same-sex domestic partner L – Opposite-sex domestic partner 5 Must be a tax dependent of retiree or spouse/domestic partner unless SSI exception applies
Eligible children: C – Child (natural or adopted) N – Overage disabled child⁵ K – Same-sex spouse or partner's grandchild⁶ or child 6 Must be a tax dependent of retiree or spouse/domestic partner
 P – Stepchild W – Legal ward⁷ G – Grandchild⁶ 7 Must be a tax dependent of retiree

1.	Name (Last, First, MI)	Sex	Relationship Code (see above)	Birthdate MO DY YR	Social Security Number (required)	Action			Primary Care Physician or Medical Group I.D. number (if required, and this section is blank, one will be assigned)	Check if Current Physician
						Med	Dent	Leg		
1.	RETIREE LISTED IN SECTION 1		RETIREE		LISTED IN SECTION 1	LISTED IN SECTION 3				
2.						<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C		
3.						<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C		
4.						<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C		

5. SIGNATURE: I have read and understand the "Participation Terms and Conditions" on the back of this form. I certify under penalty of perjury that the above information is true to the best of my knowledge.

SIGNATURE OF RETIREE	DATE	DAYTIME PHONE ()
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FOR CAMPUS/LAB/HR USE ONLY

DATE LAST PREMIUMS PAID AS EMPLOYEE: Medical: _____ Dental: _____ Legal: _____	SUBJECT TO GRADUATED ELIGIBILITY (hired or rehired after 1/1/90) <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, INDICATE LATEST UCRP ENTRY DATE: _____	ESTIMATED SERVICE CREDIT: _____	SIGNATURE OF BENEFITS REPRESENTATIVE
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REMARKS:

SEE REVERSE FOR PRIVACY NOTIFICATIONS

WHITE: RASC
 YELLOW: RETIREE COPY

PARTICIPATION TERMS AND CONDITIONS

Your Social Security number is required for purposes of benefit plan administration, for financial reporting, to verify your identity, or for legally required reporting purposes, all in compliance with federal and state laws.

As a participant in UC-sponsored plans, you are subject to the following terms and conditions:

1. With the exception of benefits provided by United Behavioral Health, UC-sponsored medical plans 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.
2. UC and UC health plan vendors comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal/state regulations related to the privacy of personal health information. To fulfill their contracted responsibilities and services, health plans and associated service vendors may share UC member health information between and among each other within the limits established by HIPAA and federal/state regulations for purposes of health care operations, payment, and treatment. A member's requested restriction on the sharing of specified protected health information for health care operations, payment and treatment will be honored as required by HIPAA.
3. By making an election with your written or electronic signature, you are authorizing the University to take deductions from your earnings (employees)/monthly Retirement Plan income (retirees) to cover your contributions toward the monthly costs, if any, for the plans you have chosen for yourself and your eligible family members.
4. You are subject to 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."
5. If you enroll family members, the University and/or carrier may require proof of eligibility. Marriage or birth certificates, domestic partner verification, adoption papers, tax records, and the like may be requested. You are required to provide such documentation upon request.
6. Under current Internal Revenue Service rules, the value of the contribution UC makes toward the cost of medical coverage provided to certain family members who are not *your* tax dependents may be considered imputed income that will be subject to federal income taxes, FICA (Social Security and Medicare), and any other required payroll taxes.
7. If you specifically ask UC representatives to intercede on your behalf with your insurance plan, University representatives will request the minimum necessary protected health information required to assist you with your problem. If more protected health information is needed to solve your problem, in compliance with state laws and federal privacy laws, including HIPAA (Health Insurance Portability and Accountability Act of 1996), you may be required to sign an authorization allowing UC to provide the insurance plan with relevant protected health information or authorizing the insurance plan to release such information to the University representative.
8. Actions you take during Open Enrollment will be effective the following January 1, unless otherwise stated—provided all electronic and form transactions have been completed properly and submitted timely.
9. You certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in the UC publications, *Group Insurance Eligibility Factsheet for Employees and Eligible Family Members* and *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*. 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.
10. Making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility within 31 days of such loss, or failing to provide documentation when requested may lead to de-enrollment of the affected family members and possible legal action. In addition, employees/retirees may be subject to disciplinary action (e.g., loss of health benefits for up to 12 months) and may be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) NOTIFICATION FOR MEDICAL PROGRAM ELIGIBILITY

If you are declining enrollment for yourself or your eligible family members because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your eligible family members* in a UC-sponsored medical plan if you or your family members lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage for you or your family members.) You must request enrollment within 31 days after you or your family member's other medical coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a newly eligible family member as a result of marriage or domestic partnership, birth, adoption, or placement for adoption, you may be eligible to enroll your newly eligible family member. If you are an employee, you may be eligible to enroll yourself and your eligible family member(s). You must request enrollment within 31 days after the marriage or partnership, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible family member because of coverage under Medicaid (in California, Medi-Cal) or under a state children's health insurance program (CHIP), you may be able to enroll yourself and your eligible family members in a UC-sponsored plan if you or your family members lose eligibility for that coverage. You must request enrollment within 60 days after your coverage or your family members' coverage ends under Medicaid or CHIP.

Also, if you are eligible for health coverage from UC but cannot afford the premiums, some states have premium assistance programs that can help pay for coverage. For details, see the Notice provided in UC's Open Enrollment booklet or call your Benefits Office. You may also contact the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services at www.cms.gov or 1-877-267-2323, ext. 61565.

If you do not enroll yourself and/or your family member(s) in medical coverage within the 31 days when first eligible or within a special enrollment period described above, you may enroll at a later date. However, each member will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective and your premiums may need to be paid on an after-tax basis, or you/they can enroll during the next Open Enrollment Period.

To request special enrollment or obtain more information, employees should contact your local Benefits Office and retirees should call the UC Customer Service Center (1-800-888-8267).

Note: If you are enrolled in a UC medical plan, you may be able to change medical plans if:

- you acquire a newly eligible family member; or
- your eligible family member loses other coverage.

In either case, you must request enrollment within 31 days of the occurrence.

*** To be eligible for plan membership, you and your family members must meet all UC employee or retiree enrollment and eligibility requirements. As a condition of coverage, all plan members are subject to eligibility verification audit by the University and/or insurance carriers.**

By authority of The Regents, University of California Human Resources, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. Source documents are available for inspection upon request (1-800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received.

The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees, and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact your Human Resources Office and retirees should call the UC Customer Service Center (1-800-888-8267).

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, CA 94607, and for faculty to Associate Director of Academic Personnel, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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 premium-free Medicare Part A.

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 Vice President—University of California Human Resources, 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.