

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

HEALTH AND WELFARE PLANS

UPAY 850 (R10/11) University of California Human Resources

INSTRUCTIONS

Use this form to enroll in, change, de-enroll/cancel, or opt out of insurance and/or flexible spending account (FSA) plans for yourself and/or your eligible family members. For complete information on eligibility, effective dates, and allowable actions, see *Your Group Insurance Plans*, the *Health Flexible Spending Account Summary Plan Description*, and the *DepCare Flexible Spending Account Summary Plan Description*, available on the At Your Service website (atyourservice.ucop.edu) or from your department or Benefits Office.

For all actions, complete Section 1, “Personal Information” and Section 8, “Signature.” Complete Section 2, if you are opting out of coverage for the reasons listed in that section. If you are enrolling or de-enrolling yourself or a family member or making some other change, complete Section 3; then complete Sections 4, 5, 6, and/or 7, as applicable. If the action you

are taking is to enroll or de-enroll a family member or change plans, be sure to list 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. 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 (atyourservice.ucop.edu; select “Sign in to My Accounts” and “My Beneficiaries”) or use form UBEN 116. You are automatically the beneficiary of a family member under the Expanded Dependent Life and/or AD&D insurance plans. To designate a different beneficiary, use form UBEN 119.

HEALTH AND DEPCARE FSA

The charts below describe the mid-year election actions that are allowed under the Health Flexible Spending Account (Health FSA) and Dependent Care Flexible Spending Account (DepCare FSA). If you are enrolled in the Health FSA and going on an unpaid family medical leave (FML), you must complete Section 6a. Before the leave begins, you must either cancel coverage, or select one of the two FML "Continue" options.

HEALTH FSA LIFE STATUS CHANGE EVENTS

CODE	CHANGE IN MARITAL STATUS				
		ENROLL	INCREASE	DE-ENROLL	DECREASE
A-1	You marry	YES	YES	NO	NO
A-2	You marry and either • you and/or your dependent become eligible under and enroll in your new spouse's own employer's health plan, or • your spouse is enrolled in his or her own employer's health FSA	NO	NO	YES	YES
A-3	You lose your legal spouse through death, divorce, legal separation or annulment	NO	NO	NO	YES
A-4	You lose your legal spouse through death, divorce, legal separation or annulment and you and/or your dependent lose coverage under your spouse's employer's health plan or health FSA	YES	YES	NO	NO
CODE GAIN OR LOSS OF A DEPENDENT					
B-1	You gain an eligible dependent (for example, through birth, adoption, or your eligible child moves in with you)	YES	YES	NO	NO
B-2	You lose an eligible dependent or a dependent loses eligibility (for example, through death, or when an individual who must be your tax dependent is no longer financially supported by you)	NO	NO	YES	YES
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 self and you in own employer's health plan, because you/he/she • starts employment, or • has an employment status change	NO	NO	YES	YES
C-2	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	YES	YES	NO	NO

For additional information regarding coverage effective dates, contact your Benefits Office or the person in your department who handles benefits. For more information about these plans, see the *Health FSA Summary Plan Description* and the *DepCare FSA Summary Plan Description*.

DEPCARE FSA LIFE STATUS CHANGE EVENTS

CODE	CHANGE IN MARITAL STATUS				
		ENROLL	INCREASE	DE-ENROLL	DECREASE
A-1	You marry and gain a dependent	YES	YES	NO	NO
A-2	You marry and your spouse is either not employed, or is enrolled in his or her own employer's dependent care FSA	NO	NO	YES	YES
A-3	You lose your spouse through death, divorce, legal separation or annulment and your spouse was enrolled in his or her own employer's dependent care FSA	YES	YES	NO	NO
CODE GAIN OR LOSS OF A DEPENDENT					
B-1	You gain an eligible dependent (for example, through birth, adoption, or your spouse becomes incapable of self-care)	YES	YES	NO	NO
B-2	You lose an eligible dependent (for example, through death, a child reaches age 13, or a child is no longer a tax dependent)	NO	NO	YES	YES
CODE CHANGE IN EMPLOYMENT STATUS					
C-1	Your spouse gains eligibility for and enrolls in own employer's dependent care FSA because he/she starts employment, or has an employment status change	NO	NO	YES	YES
C-2	Your spouse loses eligibility in own employer's dependent care FSA because he/she ends employment, or has an employment status change. Note that in order for a married employee to be or remain eligible for DepCare, the spouse must either be employed or be looking for employment (or, if not, must be a full-time student or incapable of self-care).	YES	YES	NO	NO
CODE COST CHANGE (DOES NOT APPLY IF PROVIDER IS YOUR RELATIVE BY BLOOD OR MARRIAGE)					
D-1	Your dependent care provider increases the cost of services	YES	YES	YES	YES
D-2	There is a decrease in provider's cost	YES	NO	NO	YES
CODE CHANGE IN PROVIDER OR COVERAGE					
E-1	You change dependent care providers	YES	YES	YES	YES
E-2	There is a reduction in hours or cessation of dependent care (for example, a child starts attending school)	NO	NO	YES	YES
E-3A	You change (in whole or in part) from paid care to no care or free care (for example, free care by a neighbor or relative or for state-paid care)	NO	NO	YES	YES
E-3B	You change (in whole or in part) from free or no care to paid care	YES	YES	NO	NO
E-4	Your spouse starts employment	YES	YES	NO	NO
E-5	Your spouse ends employment	NO	NO	YES	YES
E-6	You or your spouse changes work schedule (for example, going from full-time to part-time or vice versa) which creates, changes or eliminates need for dependent care.	YES	YES	YES	YES
E-7	Your spouse who is not employed or looking for employment becomes a full-time student, or becomes incapable of self-care	YES	NO	NO	NO
E-8	Your spouse who is not employed or looking for employment is no longer a full-time student or is no longer capable of self-care	NO	NO	YES	NO

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

UPAY 850 (R10/11) University of California Human Resources

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.

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

1. PERSONAL INFORMATION

NAME (Last, First, Middle Initial)	EMPLOYEE I.D. NO.	DAYTIME PHONE ()
HOME ADDRESS (Number, Street, City, State, ZIP)	WORK EMAIL ADDRESS	

2. 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 retiree under a University-sponsored plan(s).
 Covered participant's Social Security No.: _____ .
- I am currently covered under a non-UC-sponsored group plan(s).
- I wish to decline coverage due to 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. EMPLOYEE ACTIONS

Check all that apply, write in date of event (if applicable):

ENROLL: Complete Sections 4–8

- Hire/rehire (date: _____)
- Birth/adoption (date: _____)
- Marriage/domestic partnership (date: _____)
- Involuntary loss of coverage (date: _____)
- Return from leave/furlough (date: _____)
- Change in appointment status (date: _____)
- Inter-campus transfer (previous location: _____ ; attach UFIN 301)
- Late enrollment—medical only (90-day delayed effective date: _____)
- Other (explain in comments box below)

CANCEL: Complete Sections 2 and 8; OR 3–8

- Divorce, legal separation, annulment (date: _____)
- Death (date: _____)
- Child over age 26 (date: _____)
- Adult dependent relative, legal ward (date: _____)
- Family member (date: _____)
- Termination of domestic partnership (date: _____)
- Other (explain in comments box below)

CHANGE

- Open Enrollment (effective January 1 of the following year):
Complete Sections 4 and 6–8
- Life insurance: **Complete Sections 5 and 8**
- Disability waiting period: **Complete Sections 5 and 8**
- Move out of/return to plan's service area (date: _____):
Complete Sections 4 and 8
- Personal data for eligible family member (date: _____):
Complete Sections 7 and 8
- Other (explain in comments box below)

Comments:

4. MEDICAL, DENTAL, VISION, LEGAL, AND TIP

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
Health Net Blue & Gold ^{1,2}	<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel
Kaiser—CA ¹	<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel
Western Health Advantage ^{1,2}	<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel
Core	<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel
Anthem Blue Cross PLUS ¹	<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel
Anthem Blue Cross PPO	<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel
Anthem Lumenos PPO with HRA ²	<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel
Other: _____	<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel

Name your Primary Care Physician or Medical Group I.D. number in Section 7.

¹ You must live in the plan’s service area.

² Available to non-Medicare members only

DENTAL

Delta Dental PPO

Enroll Cancel

DeltaCare® USA; (Dental HMO; CA residents only)

Enroll Cancel

VISION

Vision Service Plan (VSP)

Enroll

(See Section 2, to opt out of vision coverage.)

LEGAL

ARAG Legal Plan

Enroll Cancel

Legal Plan is not open for enrollment during Open Enrollment every year. Check the At Your Service website for information. However, you may enroll during a PIE.

TAX SAVINGS ON INSURANCE PREMIUMS (TIP)

Enroll Cancel

The TIP program allows employees to pay any medical/dental/vision premiums on a pretax, salary reduction basis. You cannot enroll or cancel/decline TIP participation mid-year unless you are enrolling as a new hire or you have made a permitted election to de-enroll in a health plan(s) for which you have been making payments on a pretax basis.

5. OTHER INSURANCE PLANS—SEE FORM INTRODUCTION FOR INFORMATION ON NAMING BENEFICIARIES FOR LIFE INSURANCE AND AD&D PLANS

Employee only

SUPPLEMENTAL DISABILITY

Enroll (Check one):

Cancel 7 Days

Change Waiting Period 30 Days

90 Days

180 Days

WAITING PERIOD: The waiting period you select for Supplemental Disability will also apply to Short-Term Disability.

(NOTE: You must also submit a Statement of Health to decrease your waiting period.)

SUPPLEMENTAL LIFE

Enroll (Check one):

Cancel 1 Times Annual Salary

Change 2 Times Annual Salary

3 Times Annual Salary

4 Times Annual Salary

Flat Amount (\$20,000)

(NOTE: You will be required to submit a Statement of Health to increase your coverage level.)

Employee and/or eligible family members

DEPENDENT LIFE

Enroll (Check one):

Cancel **Basic Plan**

Change Spouse/Domestic Partner and Children, as applicable

Expanded Plan

Spouse/Domestic Partner Only

Spouse/Domestic Partner and Child(ren)

Child(ren) Only

ACCIDENTAL DEATH & DISMEMBERMENT

Enroll (Check one):

Cancel Self

Change Two Adults

Two Adults + Children

Adult + Children

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	

6. HEALTH FSA AND DEPCARE FSA—You must reenroll in this benefit every year.

The effective date for enrollment or change actions is the first of the month following your change or enrollment, subject to payroll deadlines.

Enroll: Code (for example A-1) _____

De-enroll: Code (for example C-1) _____

Change Contribution (increase or decrease): Code (for example B-2) _____

Enter your contribution amount:

Health FSA \$ _____/year

DepCare FSA \$ _____/year

Life Status Change—Changes permissible due to these events must be on account of and correspond with the event. Check the reason you are completing the form, enter the code for the event that applies to you (refer to chart on page 2) and your contribution amount.

Your monthly contribution will be calculated by dividing the annual amount you elect by the number of months that remain in the calendar year.

6a. For Health FSA only—Approved Family Medical Leave (FML)

During my Family Medical Leave without pay:

Cancel my coverage

Continue my coverage. Upon my return, my monthly contribution will be the same as before the leave and the annual amount will be reduced by the number of contributions missed while on leave.

Continue my coverage. Upon my return, my annual contribution amount will be the same as before the leave and I will make up contributions to reach the annual elected amount.

7. ADDITIONAL EMPLOYEE INFORMATION AND 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 3, "Employee Actions."

In the Action box below, check "E" for enroll or "D" for de-enroll. Enter the appropriate relationship code (see below) to indicate the family member's relationship to you. (Codes D, L, and K may be subject to imputed income unless tax dependent of employee for federal purposes.) Check the appropriate insurance plan box (Med, Dent, Vis, Leg) in Section 4.

ADULTS—You may only enroll one eligible adult. Relationship Codes: S – Opposite-sex spouse D – Same-sex spouse or same-sex domestic partner
L – Opposite-sex domestic partner

Action	Name (Last, First, MI)	Sex	Relationship (use codes)	Birthdate	Social Security Number (required)	Med	Dent	Vis	Leg	Primary Care Physician or Medical Group I.D. (if required, and this section is blank, one will be assigned)	Check if Current Physician
<input type="checkbox"/> E <input type="checkbox"/> D	1. LISTED IN SECTION 1		SELF	MO DY YR 		LISTED IN SECTION 3				Name _____ ID No: _____	<input type="checkbox"/>
<input type="checkbox"/> E <input type="checkbox"/> D	2.			MO DY YR 						Name _____ ID No: _____	<input type="checkbox"/>

CHILDREN—Enter the relationship code to indicate the family member's relationship to you: C – Child (natural or adopted) P – Stepchild N – Overage disabled child¹
K – Same-sex spouse or partner's grandchild² or child G – Grandchild² W – Legal ward³

1 Must be a tax dependent of employee or spouse/domestic partner unless SSI exception applies

2 Must be a tax dependent of employee or spouse/domestic partner

3 Must be a tax dependent of employee

Action	Name (Last, First, MI)	Sex	Relationship (use codes)	Birthdate	Social Security Number (required)	Med	Dent	Vis	Leg	Primary Care Physician or Medical Group I.D. (if required, and this section is blank, one will be assigned)	Check if Current Physician
<input type="checkbox"/> E <input type="checkbox"/> D	3.			MO DY YR 						Name _____ ID No: _____	<input type="checkbox"/>
<input type="checkbox"/> E <input type="checkbox"/> D	4.			MO DY YR 						Name _____ ID No: _____	<input type="checkbox"/>
<input type="checkbox"/> E <input type="checkbox"/> D	5.			MO DY YR 						Name _____ ID No: _____	<input type="checkbox"/>
<input type="checkbox"/> E <input type="checkbox"/> D	6.			MO DY YR 						Name _____ ID No: _____	<input type="checkbox"/>

8. SIGNATURE

My signature below indicates I have read and understand the "Terms and Conditions" on page 6 of this form. I declare under penalty of perjury that all of the above information is true to the best of my knowledge. I agree it is my responsibility to check my earnings statement each month to verify my current benefits enrollments and deductions and to alert my Payroll/Benefits Office immediately of any errors. I understand that the University may not be able to remedy problems identified beyond 30 days.

EMPLOYEE'S SIGNATURE	DATE	SYSTEM UPDATED BY	TELEPHONE NUMBER	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.

SEE PAGE 7 FOR PRIVACY NOTIFICATIONS

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.

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.

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) 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.**

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.