# RETIREE CONTINUATION, ENROLLMENT, OR CHANGE—MEDICAL, DENTAL AND/OR LEGAL PLAN

**UBEN 100 (R10/09) University of California Human Resources**

Send completed form to: UC Human Resources
Retirement Insurance Program
P.O. Box 24570
Oakland, CA 94623-1570

## 1. PERSONAL INFORMATION

| NAME (Last, First, Middle Initial) | SOCIAL SECURITY NUMBER | CAMPUS/LAB LOCATION | RETIREMENT SYSTEM COVERAGE ☐ UCRP ☐ CalPERS ☐ OTHER (Specify): |
|---|---|---|---|
| ADDRESS (Number, Street) | (City, State, ZIP) | | |

## 2. ACTIONS

Add eligible family member(s):
- ☐ Opposite-sex spouse (date of marriage: _____)
- ☐ Same-sex spouse (date of marriage: _____)
- ☐ Domestic partner (refer to *Group Insurance Eligibility Factsheet* for definition):
  - __ Registered with State of CA (filing date: _____)
  - Not registered with State of CA. I certify I can provide required documentation to verify eligibility (date partnership began: _____)
- ☐ Other eligible family member

☐ Change plans/enroll during Open Enrollment or during a Period of Initial Eligibility
☐ Move out of/return to plan's service area (date: _____)

☐ Other (specify: _____) (e.g., HIPAA 90-day delayed effective date, or provider disruption)
De-enroll family member (name: _____) (effective date: _____) for following reason:
- ☐ Divorce, legal separation, annulment
- ☐ Termination of domestic partnership registered with State of CA (filing date of termination:_____)
- ☐ Termination of partnership not registered with State of CA (date relationship ended:_____)
- ☐ Other: _____

☐ Transfer coverage from employment to: ☐ retirement ☐ disability ☐ other: _____
☐ Suspend medical plan coverage due to ☐ TRICARE For Life ☐ other group/individual coverage
☐ Involuntary loss of coverage (date coverage loss: _____)

| **Medical Plan** | ENROLL | CANCEL | SUSPEND |
|---|---|---|---|
| Health Net[1] | ☐ | ☐ | ☐ |
| Kaiser–CA[1] | ☐ | ☐ | ☐ |
| Core | ☐ | ☐ | ☐ |
| Western Heath Advantage[1] | ☐ | ☐ | ☐ |
| Anthem Blue Cross PLUS[1] | ☐ | ☐ | ☐ |
| Anthem Blue Cross PPO | ☐ | ☐ | ☐ |
| High Option Supplement to Medicare[2] | ☐ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ | ☐ |

1 You must live in plan's service area  2 Call the UC Customer Service Center (1-800-888-8267) for eligibility information

| **Dental Plan** | ENROLL | CANCEL |
|---|---|---|
| Delta Dental PPO | ☐ | ☐ |
| DeltaCare® USA (Dental HMO; CA residents only) | ☐ | ☐ |

| **Legal Plan** | ENROLL | CANCEL |
|---|---|---|
| ARAG Legal Plan (Legal Plan is not open for enrollment during Open Enrollment every year.) | ☐ | ☐ |

## 3. ENROLLEE INFORMATION List yourself and all eligible family members added in Section 2. Do not include deleted family members below.

Enter the Relationship Code in box below: **You may only enroll one adult other than yourself:** Relationship codes: Legal spouse **(S)**, Same-sex spouse or same-sex domestic partner **(D)**, Opposite-sex domestic partner **(L),** Adult dependent relative* **(A)** (see footnote 2 on reverse); **Eligible children:** Tax-dependent child (natural, adopted, or overage disabled)* **(C)**, Non-tax dependent child (natural or adopted) **(T)**; Non-tax dependent overage disabled child **(N)**, Same-sex spouse or partner's child/grandchild* **(K)**, Stepchild* **(P)**, Legal ward* **(W)**, Grandchild* **(G)**, Other child (enrolled before 9/1/94)* **(O)**. * Must be a tax dependent

| | Name (Last, First, MI) | Sex | Relationship Code (see above) | Birthdate MO DY YR | Social Security Number (required) | ☒ TO ENROLL Med | Dent | Leg | Primary Care Physician or Medical Group I.D. number (if required, and this section is blank, one will be assigned) | Check if Current |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. | RETIREE LISTED IN SECTION 1 | | RETIREE | | LISTED IN SECTION 1 | LISTED IN SECTION 2 | | | | |
| 2. | | | | | | ☐ | ☐ | ☐ | | ☐ |
| 3. | | | | | | ☐ | ☐ | ☐ | | ☐ |
| 4. | | | | | | ☐ | ☐ | ☐ | | ☐ |

## 4. MEDICARE (For any member age 65 or older or others eligible to enroll or enrolling in Medicare) Send UC HR a copy of the Medicare card(s) when enrolled.

The following are enrolled in Medicare: (Enter effective dates, claim numbers, and provide copies of the Medicare cards.) Check ☐ if any family members are in the process of enrolling in Medicare.

| Retiree | Retiree's Spouse or Domestic Partner | Adult Dependent Relative (does not qualify for UC coverage if eligible for Medicare Part A) | Eligible Child Name: |
|---|---|---|---|
| Effective Date | Effective Date | Effective Date | Effective Date |
| Medicare Part A: MO DY YR | Medicare Part A: MO DY YR | Medicare Part A: MO DY YR | Medicare Part A: MO DY YR |
| Medicare Part B: MO DY YR | Medicare Part B: MO DY YR | Medicare Part B: MO DY YR | Medicare Part B: MO DY YR |
| MEDICARE CLAIM NUMBER: | MEDICARE CLAIM NUMBER: | MEDICARE CLAIM NUMBER: | MEDICARE CLAIM NUMBER: |

## 5. SIGNATURE: I have read and agree to 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 ( ) |
|---|---|---|

## FOR CAMPUS/LAB USE ONLY

| DATE RETIRED | LAST DAY ON PAY STATUS | DATE LAST PREMIUMS PAID AS EMPLOYEE: Medical: | Dental: | Legal: |
|---|---|---|---|---|
| | | DATE PREMIUMS BEGAN AS RETIREE: Medical: | Dental: | Legal: |
| SIGNATURE OF BENEFITS REPRESENTATIVE | | SUBJECT TO GRADUATED ELIGIBILITY (hired or rehired after 1/1/90) | ☐ YES ☐ NO | |
| | | IF YES, INDICATE LATEST UCRP ENTRY DATE: | ESTIMATED YEARS SERVICE CREDIT: | |

## FOR UC HR USE ONLY

REMARKS:

DATE COMPLETED BY UC HR: _____ EFFECTIVE DATE: _____

**SEE REVERSE FOR PRIVACY NOTIFICATIONS**

WHITE: UC HR
CANARY: UC HR
PINK: RETIREE COPY

## PARTICIPATION TERMS AND CONDITIONS

Your Social Security number will be requested only when needed by benefit plan administration for financial reporting or to verify your identity, in compliance with federal and state law.

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

1. Most of the medical plans that UC offers [including the medical portion of Anthem Blue Cross PLUS and Anthem Blue Cross PPO*, Health Net, Western Health Advantage, and CIGNA Choice Fund], Core and High Option Supplement to Medicare (offered by Anthem Blue Cross Life and Health Insurance Company)*, and Kaiser Permanente—CA 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 monthly costs, if any, for the plans you have chosen for yourself and your eligible family members.
4. 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".
5. 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.
6. If you enroll your eligible same-sex spouse or domestic partner and/or your same-sex spouse's or domestic partner's eligible child(ren) or grandchild(ren), or if you enroll or have enrolled your natural or adopted child who is not claimed as your tax dependent, you acknowledge that the UC/employer contribution for their medical and/or dental and/or vision coverage may be reported as income to you and (where appropriate) may be subject to FICA (Social Security and Medicare) and/or federal/state income tax withholding.
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 privacy laws and federal 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.
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 will lead to de-enrollment of the 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 will be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage.

[1] Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association.

## 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.

## 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[3] 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 your 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 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 do not enroll yourself and/or your family member(s) within the 31 days when first eligible, 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, or you/they can enroll during the next Open Enrollment Period.

To request special enrollment or obtain more information, contact the UC Customer Service Center.

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.

[3] **To be eligible for plan membership you and your family members must meet all UC eligibility requirements for coverage as stated in the *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*. As a condition of coverage, all plan members are subject to eligibility verification audit by the University and/or insurance carriers.**