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

HEALTH AND WELFARE PLANS

UPAY 850 (R10/10) University of California Human Resources

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 (atyourservice.ucop.edu) or from your department or Benefits Office.

If the action you require is to enroll or de-enroll a family member or change plans, you must complete Sections 1, 2, 3, 4, and 5. 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.

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 agree 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 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, domestic partner verification, 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 an eligible child or grandchild of your same-sex spouse or domestic partner and such family member 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 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 properly completed.
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.

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.

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 Director of Diversity and Employee Programs, University of California, Office of the President, 300 Lakeside Drive, Oakland, CA 94612, 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.

Also, 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.

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.

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

UPAY 850 (R10/10) University of California Human Resources
If you have enrolled online using the At Your Service website, do not use this form.

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. Once this form is submitted, your Period of Initial Eligibility (PIE) ends. Shaded areas should be completed by the person updating the online system.

1. PERSONAL INFORMATION

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	CAMPUS/LAB AND DEPARTMENT	CAMPUS/LAB PHONE	EMPLOYEE I.D. NO.
Saito, Rintaro	(Pending)	Medicine and Bioengineer	(858) 822-4667	000726287

HOME ADDRESS (Number, Street, City, State, ZIP)	HOME PHONE
5205 Fiore Terrace #413, San Diego, CA 92122	(858) 752-7176

2. EMPLOYEE ACTIONS

TYPE OF ACTION OR QUALIFYING EVENT (check all that apply):

- [x] New hire (date: Feb. 1, 2011)
- [ ] Rehire (date: _____)
- [x] **Open Enrollment (effective 01/01/ of the following year)**

Add eligible family member:

- [x] Opposite-sex spouse (date of marriage: July 5, 2009)
- [ ] Same-sex spouse (date of marriage: _____)
- [ ] Domestic partner (refer to the *Group Insurance Eligibility Factsheet* for definition):
  - [ ] Registered with the State of California (filing date: _____)
  - [ ] Not registered with the State of California. I certify I can provide the required documentation to verify eligibility. (date partnership began: _____)

WRITE IN DATE OF EVENT, if applicable.

- [ ] Other eligible family member (explain in comments box below)
- [ ] Cancel coverage indicated below (date: _____)
- [ ] De-enroll family member (date: _____) Reason:
  - Divorce, legal separation, annulment
  - Termination of partnership registered with the State of California (filing date of termination: _____)
  - Termination of partnership not registered with the State of California (date relationship ended: _____)
  - Loss of eligibility for adult dependent relative
  - Loss of eligibility for dependent child status
  - Other (provide reason in comments box below)
- [ ] Change in appointment status (date: _____)
- [ ] Change personal data for eligible family member (date: _____)
- [ ] Inter-campus transfer (previous location: _____)
- [ ] Move out of/return to plan's service area (date: _____)
- [ ] Statement of Health (Life/Disability only)
- [ ] Cancel previous opt out request
- [ ] Involuntary loss of coverage (date: _____) (Please attach a letter from the employer certifying that you and/or your family member(s) were enrolled in the plan(s) and specifying the date coverage ends.)
- [ ] Begin leave/furlough (date: _____)
- [ ] Return from leave/furlough (date: _____)
- [ ] Other (specify: _____) (e.g., HIPAA 90-day delayed effective date, provider disruption)
- [ ] Opt out of [ ] re-enroll in the Tax Savings on Insurance Premiums (TIP)
- [ ] Change coverage indicated below

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 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. 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 de-enrolled.

MEDICAL

	Enroll	Cancel
Health Net[1]	[ ]	[ ]
Health Net Blue & Gold[1, 2]	[x]	[ ]
Kaiser—CA[1]	[ ]	[ ]
Western Health Advantage[1, 2]	[ ]	[ ]
Core	[ ]	[ ]
Anthem Blue Cross PLUS[1]	[ ]	[ ]
Anthem Blue Cross PPO	[ ]	[ ]
Anthem Lumenos PPO with HRA	[ ]	[ ]
Other: _____	[ ]	[ ]

Coverage Effective Date (MO DY YR): 02 01 11

Name your Primary Care Physician or Medical Group I.D. number in Section 5.

[1] You must live in the plan's service area.
[2] Available to non-Medicare members only

DENTAL

Coverage Effective Date (MO DY YR):

Delta Dental PPO

- [ ] Enroll [ ] Cancel

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

- [ ] Enroll [ ] Cancel

VISION

Coverage Effective Date (MO DY YR): 02 01 11

Vision Service Plan (VSP)

- [x] Enroll

(You may not cancel vision coverage, due to internal procedures. However, you may opt out of vision coverage; see Section 2A, above.)

LEGAL

Coverage Effective Date (MO DY YR):

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. You may enroll during a PIE, however.

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

Employee only

SUPPLEMENTAL DISABILITY

Coverage Effective Date MO DY YR

- ☐ Enroll
- ☐ Cancel
- ☐ Change Waiting Period

(Check one):

- ☐ 7 Days
- ☐ 30 Days
- ☐ 90 Days
- ☐ 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

Coverage Effective Date MO DY YR

- ☐ Enroll
- ☐ Cancel
- ☐ Change

(Check one):

- ☐ 1 Times Annual Salary
- ☐ 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

Coverage Effective Date MO DY YR

- ☐ Enroll
- ☐ Cancel
- ☐ Change

(Check one):

- ☐ Basic Plan (spouse/domestic partner and children, as applicable)
- ☐ Expanded Plan (select type of coverage)
  - ☐ Spouse/Domestic Partner Only
  - ☐ Spouse/Domestic Partner and Child(ren)
  - ☐ Child(ren) Only

ACCIDENTAL DEATH & DISMEMBERMENT

Coverage Effective Date MO DY YR

- ☐ Enroll
- ☐ Cancel
- ☐ Change

(Check one):

- ☐ Self
- ☐ Family
- ☐ Modified Family

COVERAGE AMOUNT (Check one):

☐ $10,000	☐ $70,000	☐ $175,000
☐ $20,000	☐ $80,000	☐ $200,000
☐ $30,000	☐ $90,000	☐ $300,000
☐ $40,000	☐ $100,000	☐ $400,000
☐ $50,000	☐ $125,000	☐ $500,000
☐ $60,000	☐ $150,000	

5. 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 2, "Employee Actions."

In the Action box below, check "E" for enroll or "D" for de-enroll. If you are enrolling or de-enrolling family members, show the date of the event (marriage, birth, adoption, divorce, death, or domestic partnership or termination of partnership). Enter the appropriate relationship code (see below) to indicate the family member's relationship to you. Check the appropriate insurance plan box (Med, Dent, Vis, Leg) in Section 3. If you enroll in a plan which requires you to select a Primary Care Physican (PCP) or medical group and you do not select one, one will be selected for you.

Action	Date of Event	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.	Check if Current Physician
ADULTS—You may only enroll one eligible adult. Relationship Codes: Legal spouse **(S)**, Same-sex spouse or same-sex domestic partner **(D)**, Opposite-sex domestic partner **(L)**, Adult dependent relative **(A)**: See note on reverse.												
Check E or D below	MO DY YR	1. LISTED IN SECTION 1	M	SELF	MO DY YR	LISTED IN SECTION 1	LISTED IN SECTION 3				Name Brown, Edward ID No:	☐
☑ E ☐ D	02 01 11	2. Saito, Ayako	F	S	09 26 70	(Not Applicable)	☑	☐	☑	☐	Name Brown, Edward ID No:	☐
CHILDREN—Enter the relationship code to indicate the family member's relationship to you: 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												
☐ 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 declare 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	TELEPHONE NUMBER	DATE

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 REVERSE FOR PRIVACY NOTIFICATIONS

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