UPlan

Application for Coverage: Active Employee

Office of Human Resources
University of Minnesota
Driven to Discover®

Please complete entire application

Employee Information *(please print)*

Last Name	First Name	MI	Employee ID Number
Zhou	Peng		4114401

Date of Birth *(MM/DD/YY)*	Phone number	Email address
01/31/1986	6125323168	zhoux379@umn.edu

Medical Plan

- [x] Medica Elect/Essential (Twin Cities and Duluth Only)
- [ ] Medica Choice National
- [ ] Medica HSA
  - [ ] I elect an additional annual HSA amount of $ _____
  - [ ] I am age 55+ & elect an HSA catch up amount of $ _____
- [ ] ACO-VantagePlus with Medica (Twin Cities Only)
- [ ] ACO-Park Nicollet First (Twin Cities Only)
- [ ] ACO-Ridgeview Community Network (Twin Cities Only)
- [ ] Medica Choice Regional (Greater Minnesota Only)
- [ ] ACO-Altru & You (Crookston Only)
- [ ] ACO-Essentia Choice Care (Northern Minnesota Only)
- [ ] ACO-Medica CompleteHealth-Mayo (Rochester Only)

Note: You must live or work in the area served by the ACO you choose

Select Coverage Level:

- [ ] Employee only
- [ ] Employee & children
- [x] Employee & Spouse with or without children
- [ ] I elect to waive coverage

Dental Plan

- [x] Delta Dental PPO
- [ ] Delta Dental Premier

Select Coverage Level:

- [ ] Employee only
- [ ] Employee & children
- [ ] Employee & Spouse with or without children
- [ ] I elect to waive coverage

Enrollees for Medical and/or Dental Plans: *(complete requested information for self and eligible dependents)*

Medical	Dental	Relationship	Last Name	First Name	Social Security No.	Gender (M/F)	Date of Birth (MM/DD/YY)	Primary Care Clinic Code*
☑	☑	Self:	Zhou	Peng	477539035	M	01/31/1986	0000001011
☑	☑	Spouse:	Zheng	Ye	846163171	F	10/26/1992	0000001011
☑	☑	Child – birth to age 26	Zhou	Bryce	770379390	M	06/09/2020	0000012165
☐	☐	Child – birth to age 26						
☐	☐	Child – birth to age 26						

*A Primary Care Clinic code is required for enrollment in Medica Elect/Essential. Failure to add a correct number will result in an enrollment error.

I verify that I read the definition of eligible dependents at https://z.umn.edu/dependenteligibility or in the enrollment guide, and my dependents are eligible. I will be able to provide documentation for each dependent when requested.

Basic Employee Life Insurance

- [x] I elect Basic Life Insurance. (You pay the full premium if your appointment is 50-74% time. Premium is paid by the University for 75-100% time.)
- [ ] I elect Basic Life Insurance capped at $50,000. (By capping the amount, you avoid paying tax on the premium value for Basic Life Insurance over $50,000.)

Pre-tax Flexible Spending Accounts

If you are a new employee, elect a total amount from your effective date of coverage to the end of this calendar year.

Health Care Flexible Spending Account: I elect an annual contribution of $_____($100 minimum, $2,700 maximum) for this calendar year.
(For out-of-pocket medical, dental, or vision expenses)

Dependent Daycare Flexible Spending Account: I elect an annual contribution of $_____($100 minimum, $5,000 maximum) for this calendar year.
(For care provided to children under age 13 or adult daycare)

Continue to back for more information

Change in Coverage

To make changes in your health coverage outside the annual Open Enrollment period there must be a family status change consistent with your request. This change must have occured **within the last 30 days.** Please check the appropriate box.

☑ Add coverage ☐ Cancel coverage ☐ I elect to change my annual HSA amount to $_____

Date of family status change: 06/09/2020

Type of family status change:

☐ Marriage (may only add coverage)

☑ Birth/adoption (may only add coverage)

☐ Divorce

☐ Spouse or other eligible dependent is newly enrolled or lost other group insurance. If person is an UMN employee or student please provide their employee ID:_____

☐ Other (please explain)_____

Information and Privacy – There are laws to protect your rights

Several state and federal laws aid in protecting your rights to privacy and make it easier for you to review information in your insurance file. Under one of these laws – the Minnesota Government Data Practices Act (Minnesota Statutes 13.01-13.43) – you have the right to know the following.

A. Why the Information is needed

The Information we request about you, your employment, and family members is needed for one or more of the following reasons:

- To determine whether you are eligible for University of Minnesota UPlan Health Program coverage
- To establish the amount of insurance coverage for which you are eligible
- To determine the amount of deductions from your paycheck to pay your rate contributions

B. Supplying Information – Your Rights

- **Minnesota Stature 13.04.** You may refuse to provide the information we request; however, without certain minimal information, we may be unable to process your application for coverage under the group plan.
- **Federal Privacy Act of 1974; Public Law 93-579.** Disclosure of your Social Security number is voluntary. The information is requested to identify your records in the Total Compensation system and the records of the Plan Administrators. While you are not legally required to furnish this information, processing of your application for group benefits will be delayed without it.

C. Who Uses the Information and How It Is Used

The information we collect will be used by University employees operating the group benefits program, the payroll system, federal and state tax authorities, and shared with the Plan Administrators involved in your benefits coverage. Depending on the coverage you request (and are eligible for), the information may be used to:

- Provide enrollment and/or change information to your Plan Administrators so they can provide benefits and pay claims
- Conduct quality improvement initiatives
- Prepare statistical reports and evaluate studies

When you are no longer an active participant in the group benefits program, your file is kept until state retention requirements are met.

D. What information You Can Access

You may request in writing to be shown information about yourself that is maintained by our department. There may be a charge if physical copies are needed.

Employee Authorization *(Please read before signing)*

I am applying for coverage in the University of Minnesota UPlan and the Pre-tax Benefits Plan, subject to approval of my eligibility. I understand that for the Pre-Tax Benefits, I cannot increase, decrease, or stop my election during the calendar year unless I have a family status change. I understand that after I have filed all claims to my pre-tax Flexible Spending Account(s) for expenses incurred by the claims deadline, I will lose any balance remaining in my account(s). If I have enrolled in the ACO Plan, I acknowledge that Medica and the ACO I have elected will share health record information to help coordinate care for me and my family. I authorize the University to deduct my share of the rates through payroll and to disclose the above information to the pan administrators and insurance carrier that I elected for use in processing my application and administering the Plan. This authorization is valid until revoked by the operation of law. I further understand that failure to notify Total Compensation on a timely basis of loss eligibility for any of my dependents or providing false information on this form may result in disciplinary action up to and including termination of employment. I agree that, if either event occurs, the University may recover damages for losses and reasonable attorney's fees by the University to recover such damages.

Peng Zhou — 08/25/2020

Employee Signature — **Date**

If you have questions, call the OHR Contact Center at 612-624-8647 or 1-800-756-2363 Option 1 for Benefits, or by email at benefits@umn.edu.
Please make a copy of this form for your records and return the original by mail or fax.

Campus Mail:
Total Compensation
100 DonhoweB
Del Code 3122A

U.S. Mail:
Total Compensation
100 Donhowe Bldg.
319 15th Avenue SE
Minneapolis, MN 55455-0103

Fax: 612-626-0808
Phone: 612-624-8647
Email: benefits@umn.edu