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

HEALTH AND WELFARE PLANS

UPAY 850 (R10/13) 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 *A Complete Guide to Your UC Health Benefits*, 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 only 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.

Blue Shield Health Savings Plan

By enrolling into the Blue Shield Health Savings Plan, a HealthEquity savings account will automatically be opened on your behalf and the UC contribution will be deposited. HealthEquity is the Blue Shield preferred account administrator for the Health Savings Account.

To participate in the Blue Shield Health Savings Plan, you must meet the following eligibility criteria:

- You cannot be enrolled in the Health Savings Plan and the Health Flexible Spending Account (Health FSA) in the same calendar year.
- You cannot be covered by any other medical plan, including Medicare. (Exception: Insurance for a specified disease or illness, e.g. cancer, is permitted. See IRS Publication 969.)
- You cannot be claimed as a dependent on another individual's tax return.
- You must have a valid U.S. address.
- If you are now enrolled in the Health FSA, and you are using this form to enroll in the Health Savings Plan, effective January 1st of next year, it is your responsibility to make sure that you have a $0 balance in your Health FSA account by December 31st of the current year.

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.

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.* You may not enroll in the Health FSA if enrolled in the Health Savings Program.

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

Note: If you are enrolled in the Health Savings Plan, these Health FSA life status change events will not apply to your HSA.

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 (R10/13) 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 (date: _____)
- ☐ Domestic partnership:
  - Registered with State of CA (filing date: _____)
  - Not registered with State of CA (date partnership began: _____)
- ☐ Involuntary loss of coverage (attach proof of loss) (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 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

Blue Shield Health Saving Plan	☐ Enroll	☐ Cancel
Monthly HSA Contribution $_____		
Core	☐ Enroll	☐ Cancel
Health Net Blue & Gold[1]	☐ Enroll	☐ Cancel
Kaiser—CA[1]	☐ Enroll	☐ Cancel
UC Care	☐ Enroll	☐ Cancel
Western Health Advantage[1]	☐ Enroll	☐ 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.

DENTAL

Delta Dental PPO

☐ Enroll ☐ Cancel

DeltaCare® USA
(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**
☐ **Cancel**
☐ **Change Waiting Period**

(Check one):
☐ 7 Days
☐ 30 Days
☐ 90 Days
☐ 180 Days

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

(NOTE: You must submit a Statement of Health to enroll outside of your original PIE or to decrease your waiting period.)

SUPPLEMENTAL LIFE

☐ **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 enroll outside of your PIE or to increase your coverage level.)

Employee and/or eligible family members

DEPENDENT LIFE

☐ **Enroll**
☐ **Cancel**
☐ **Change**

(Check one):

Basic Plan
☐ Spouse/Domestic Partner and Children, as applicable

Expanded Plan
☐ Spouse/Domestic Partner Only
☐ Spouse/Domestic Partner and Child(ren)
☐ Child(ren) Only

(NOTE: A Statement of Health is required to enroll adults outside of a PIE.)

ACCIDENTAL DEATH & DISMEMBERMENT

☐ **Enroll**
☐ **Cancel**
☐ **Change**

(Check one):
☐ Self
☐ Self and Spouse/Domestic Partner
☐ Self and Child(ren)
☐ Self and Spouse/Domestic Partner and Child(ren)

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	

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

Health FSA is not available to Blue Shield Health Savings Plan enrollees. 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) _____

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.

Enter your contribution amount:

Health FSA $_____/year

DepCare FSA $_____/year

Your contribution per pay period will be calculated by dividing the annual amount you elect by the number of pay periods 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, legal plans, Dependent Life and/or AD&D 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 and/or the appropriate insurance plan box (Life, AD&D) in Section 5.

ADULTS—You may only enroll one eligible adult. Relationship Codes: S – Spouse D – 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	Life	AD &D	Primary Care Physician or Medical Group I.D. (if required, and this section is blank, one will be assigned)	Check if Current Physician
☐ E ☐ D	1. LISTED IN SECTION 1		SELF	MO DY YR | |		LISTED IN SECTION 4						Name_____ ID No:	☐
☐ E ☐ D	2.			MO DY YR | |								Name_____ ID No:	☐

CHILDREN—Enter the relationship code to indicate the family member's relationship to you: C – Child (biological or adopted) P – Stepchild N – Overage disabled child[1]
K – Domestic partner's child[4] or grandchild[2] G – Grandchild[2] W – Legal ward[3]

[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
[4] If your domestic partnership is registered and you are considered the child's stepparent under state law, enter Code "P" for Stepchild. Otherwise, enter Code "K."

Action	Name (Last, First, MI)	Sex	Relationship (use codes)	Birthdate	Social Security Number (required)	Med	Dent	Vis	Leg	Life	AD &D	Primary Care Physician or Medical Group I.D. (if required, and this section is blank, one will be assigned)	Check if Current Physician
☐ E ☐ D	3.			MO DY YR | |								Name_____ ID No:	☐
☐ E ☐ D	4.			MO DY YR | |								Name_____ ID No:	☐
☐ E ☐ D	5.			MO DY YR | |								Name_____ ID No:	☐
☐ E ☐ D	6.			MO DY YR | |								Name_____ ID No:	☐

8. SIGNATURE

My signature below indicates I have read and understand the "Terms and Conditions" on page 6 of this form as well as the eligibility requirements of the benefit plans in which I have enrolled. 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

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 Blue Shield of California and OptumHealth, 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) to cover your contributions toward the monthly costs, if any, for the plans you have chosen for yourself and your eligible family members. You are also authorizing UC to transmit your enrollment demographic data to the plans in which you are enrolled.
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 the University of California Group Insurance Regulations.
5. By enrolling individuals as your family members, you are certifying that those individuals are eligible for coverage based on the definitions and rules specified in the University of California Group Insurance Regulations and described in UC health and welfare plan eligibility publications. You are also certifying, under penalty of perjury, that all the information you provide regarding the individuals you enroll is true to the best of your knowledge.
6. If you enroll individuals as your family members you must provide, upon request, documentation verifying that those individuals are eligible for coverage. The carrier may also require documentation verifying eligibility. Verification documentation includes but is not limited to marriage or birth certificates, domestic partner verification, adoption papers, tax records, and the like.
7. If your enrolled family member loses eligibility for UC-sponsored coverage (for example, because of divorce or loss of eligible child status), you must notify UC by de-enrolling that individual. If you wish to make a permitted change in your health or flexible spending account coverage, you must notify UC within 31 days of the eligibility loss event, although for purposes of COBRA eligibility, notice may be provided to UC within 60 days of the family member's loss of coverage. However, regardless of the timing of notice to UC, coverage for the ineligible family member will end on the last day of the month in which the eligibility loss event occurs (subject to any continued coverage option available and elected.)
8. Making false statements about satisfying eligibility criteria, failing to timely notify the University of a family member's loss of eligibility, or failing to provide verification documentation when requested may lead to de-enrollment of the affected family members. In addition, employees/retirees may be subject to disciplinary action and de-enrollment from health benefits for a period of up to 12 months and may be responsible for any UC-paid premiums due to enrollment of ineligible individuals.
9. Under current state and federal tax laws, the value of the contribution UC makes toward the cost of health coverage provided to certain family members who are not your "dependents" under state and federal tax rules may be considered imputed income that will be subject to income taxes, FICA (Social Security and Medicare), and any other required payroll taxes.
10. 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.
11. 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.

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, within a special enrollment period described above or within an open enrollment period, you may be eligible to enroll at a later date. However, even if eligible, each affected individual will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective and employee premiums may need to be paid on an after-tax basis (retiree premiums are always paid after-tax), or you/they can enroll during the next Open Enrollment Period. To request special enrollment or obtain more information, employees should contact their local Benefits Office and retirees should call the UC Retirement Administration Service Center (1-800-888-8267).

*** 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 by the University and/or insurance carriers, as described above in the participation terms and conditions.**

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 their Human Resources Office and retirees should call the UC Retirement Administration 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, Oakland, CA 94607, and for faculty to the Office of Academic Personnel, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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 IX, 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.