

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

UBEN 100 (R10/13) University of California Human Resources

Mail completed form to: RASC—Retiree Insurance Program  
P.O. Box 24570  
Oakland, CA 94623-1570  
OR fax to: 510-465-9037

For help with this form, call the UC Retirement Administration Service Center (1-800-888-8267) or your location's Health Care Facilitator; for the contact list, visit: [atyourservice.ucop.edu/directories\\_contacts/health\\_care\\_facilitator.html](http://atyourservice.ucop.edu/directories_contacts/health_care_facilitator.html)

## 1. PERSONAL INFORMATION—RETIREE, SURVIVOR OR DISABLED MEMBER

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	FORMER CAMPUS/LAB LOCATION	RETIREMENT SYSTEM COVERAGE <input type="checkbox"/> UCRP <input type="checkbox"/> CalPERS <input type="checkbox"/> OTHER (Specify):
ADDRESS (Number, Street) <input type="checkbox"/> NEW	(City, State, ZIP)	EMAIL ADDRESS <input type="checkbox"/> NEW	

## 2. ACTIONS Select plan(s) in Section 3.

**ENROLL** (documentation will be requested by Secova)

- Spouse (date of marriage: \_\_\_\_\_)
- Domestic partner:
  - Registered with State of CA (filing date: \_\_\_\_\_)
  - Not registered with State of CA. (date partnership began: \_\_\_\_\_)
- Other eligible family member (effective date: \_\_\_\_\_)
- New survivor (member date of death: \_\_\_\_\_)
- Late enrollment—medical only (90-day delayed effective date: \_\_\_\_\_)
- Involuntary loss of coverage\* (Loss of coverage date: \_\_\_\_\_)
- Other (explain in Comments below) \* Attach proof of loss

**CANCEL**

- Divorce, legal separation, annulment (date: \_\_\_\_\_)
  - Termination of domestic partnership (date: \_\_\_\_\_)
  - Death (date: \_\_\_\_\_)
  - Family member (effective date: \_\_\_\_\_)
  - Other (explain in Comments below)(effective date: \_\_\_\_\_)
- SUSPEND:** (effective date: \_\_\_\_\_)
- Medical plan due to other group/individual coverage
  - Medical plan due to TRICARE For Life
  - Dental plan due to other group/individual coverage

**CHANGE**

- Open Enrollment (effective January 1 of the following year)
- Move out of plan's service area (date: \_\_\_\_\_)
- Medicare plan not available/provider group disruption
- Transfer plans to retirement (retirement date: \_\_\_\_\_)
- Transfer plans to UCRP disability
- Other (explain in Comments below)

Comments:

**MEDICARE—Send UC a copy of the Medicare card(s) when you first enroll in Medicare.**

Retiree					Retiree's Spouse or Domestic Partner or Child (circle)												
Effective Date	Medicare Part A:	MO	DY	YR	Medicare Part B:	MO	DY	YR	Effective Date	Medicare Part A:	MO	DY	YR	Medicare Part B:	MO	DY	YR
MEDICARE CLAIM NUMBER:									MEDICARE CLAIM NUMBER:								

## 3. MEDICAL, DENTAL, AND LEGAL To de-enroll from your current plan, check "cancel." If you are enrolled in a non-UC plan, check "suspend."

MEDICAL PLAN	ENROLL	CANCEL	SUSPEND	ENROLL	CANCEL	SUSPEND	ENROLL	CANCEL	SUSPEND	DENTAL PLAN	ENROLL	CANCEL	SUSPEND	LEGAL PLAN	ENROLL	CANCEL		
Core <sup>2</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kaiser Senior Advantage <sup>1,3</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Health Savings Plan <sup>2</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delta Dental PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARAG Legal Plan	<input type="checkbox"/>	<input type="checkbox"/>
UC Care <sup>2</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health Net Blue & Gold <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Medicare PPO <sup>3</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DeltaCare® USA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Legal Plan is not open for enrollment during Open Enrollment every year.)		
Kaiser—CA <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health Net Seniority Plus <sup>1,3</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Medicare PPO without Rx <sup>3,4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(CA residents only)						
				Western Health Advantage <sup>1,2</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Option Supplement to Medicare <sup>3</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							

1 Must live in plan's service area    2 Only non-Medicare    3 All enrollees must be enrolled in Medicare Parts A & B    4 Must show proof of other Medicare Part D

## 4. ENROLLEE INFORMATION List yourself and all eligible family members referred to in Section 2. In the Action box below, check "E" for enroll or "C" for cancel.

Enter the Relationship Code in box below: **You may only enroll one adult other than yourself.** (Codes D, L, and K may be subject to imputed income unless tax dependent of retiree for federal purposes.)

**Eligible adult:** S – Spouse    D – Same-sex domestic partner    L – Opposite-sex domestic partner    5 Must be a tax dependent of retiree or spouse/domestic partner unless SSI exception applies

**Eligible children:** C – Child (biological or adopted)    N – Overage disabled child<sup>5</sup>    K – Domestic partner's grandchild<sup>6</sup> or child<sup>8</sup>    6 Must be a tax dependent of retiree or spouse/domestic partner

P – Stepchild    W – Legal ward<sup>7</sup>    G – Grandchild<sup>6</sup>    7 Must be a tax dependent of retiree

8 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."

1.	Name (Last, First, MI)	Sex	Relationship Code (see above)	Birthdate MO DY YR	Social Security Number (required)	Action			Primary Care Physician or Medical Group I.D. number (if required, and this section is blank, one will be assigned)	Check if Current Physician
						Med	Dent	Leg		
1.	RETIREE LISTED IN SECTION 1		RETIREE		LISTED IN SECTION 1	LISTED IN SECTION 3				
2.						<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C		
3.						<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C	<input type="checkbox"/> E <input type="checkbox"/> C		

## 5. SIGNATURE: I have read and understand 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 <input type="checkbox"/> NEW ( )
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### FOR CAMPUS/LAB/HR USE ONLY

DATE LAST PREMIUMS PAID AS EMPLOYEE: Medical:	Dental:	Legal:	HW-GRP CODE: <input type="checkbox"/> G1 <input type="checkbox"/> G2 <input type="checkbox"/> G3	SIGNATURE OF BENEFITS REPRESENTATIVE
SUBJECT TO GRADUATED ELIGIBILITY (hired or rehired after 1/1/90) <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, INDICATE LATEST UCRP ENTRY DATE:			ESTIMATED SERVICE CREDIT:	

REMARKS:

**SEE REVERSE FOR PRIVACY NOTIFICATIONS**

WHITE: RASC  
YELLOW: RETIREE COPY

## 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, NEGLIGENCE, 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 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. 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](http://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.**

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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.