NAVITUS (PDP) ENROLLMENT FORM FOR UC MEDICARE PPO OR UC HIGH OPTION SUPPLEMENT TO MEDICARE

UBEN 123 (R11/22) University of California Human Resources

Mail white copy to:
UC RASC
P.O. Box 24570
Oakland, CA 94623-1570

OR fax to: 800-792-5178

This Enrollment Form was sent to you because you or an eligible family member is enrolling in UC Medicare PPO or UC High Option Supplement to Medicare, which has a Medicare Prescription Drug Plan that requires you to assign your Medicare to your plan.

Each person on Medicare must complete a separate form. Please print clearly using a blue or black ballpoint pen.

- Read the entire agreement before you sign the form.
- Include a copy of your Medicare card with each form, if available.
- Sign and date your form. Electronic signatures are acceptable, typed are not.
- **White copy**—send or fax to: UC Retirement Administration Service Center
  P.O. Box 24570
  Oakland, CA 94623-1570
  fax 800-792-5178
  Yellow copy—keep for your records.
- "Enrollee" means the person assigning/coordinating their Medicare. An enrollee can be the UC retiree, spouse/domestic partner or another family member on Medicare.
- "Requested Effective Date" is the first of the month you want your Medicare plan to be effective after UC receives a signed and completed form. It is recommended you submit this form 60 days before you become eligible for and enroll in Medicare Parts A and B. (Medicare will deny forms submitted 90 days or more before the Effective Date.)
- You can assign your Medicare to only one prescription drug plan at any given time. By signing this form, any other prescription drug plan you may have could be cancelled.
- If you are eligible for premium-free Medicare Part A, UC requires you to have both Medicare Part A and B to join a prescription drug plan (PDP). If you pay a premium for Medicare Part A, contact UC for your coverage options.

Need help? Call the UC Retirement Administration Service Center (800-888-8267) or your location's Health Care Facilitator; for the contact list, visit: ucnet.universityofcalifornia.edu/contacts/health-care-facilitators.html.

FORM QUESTION	WHAT TO ENTER
Retiree Name and Social Security Number (SSN)	Enter the UC retiree's full name and SSN. **This is very important.**
Requested Effective Date	Enter a future effective date. This form must be received 60–90 days prior to your desired effective date (60 is recommended). If you leave the date blank, UC will assign the Effective Date as the first of the month you are eligible for and enrolled in Medicare, and after UC is in receipt of this completed form.
Name, if not retiree	Name of the person enrolling. If spouse, enter spouse's name.
SSN and Date of Birth	Enter the SSN and birthdate for the person enrolling.
Permanent Residence Address, City, State, ZIP	Address of enrollee. No P.O. Boxes accepted—need street address. If in a long term care facility, enter name of the facility.
Plan you are requesting	Select Medicare PPO or High Option. You may enroll in High Option if all of your family members have Medicare. If you are a family member, check the plan the retiree selected. All family members must be enrolled in the same plan as the retiree.
Medicare Card and Medicare Number (This is the 11-digit alpha-numeric number that replaced your SSN.)	Enter all numbers, letters and dates from your **red/white/blue** Medicare card **AND send a copy of the card** or your award letter from Social Security or the Railroad Retirement Board to UC. **This is very important.**
Arbitration checkbox, Signature and Date	Review entire form, all terms and conditions, sign and date here. **This is very important.**

To start your Medicare prescription drug coverage, UC must receive this form signed, dated and Arbitration Terms accepted prior to your Requested Effective Date.

NAVITUS (PDP) ENROLLMENT FORM FOR UC MEDICARE PPO OR UC HIGH OPTION SUPPLEMENT TO MEDICARE

UBEN 123 (R11/22) University of California Human Resources

Employer group: **University of California**

PERSONAL INFORMATION

RETIREE NAME (Last, First, Middle Initial)	RETIREE RETIREMENT DATE	RETIREE SOCIAL SECURITY NUMBER

CHECK IF YOU ARE:

☐ Retiree ☐ Spouse/domestic partner of the retiree ☐ Other family member on Medicare

YOUR NAME (Last, First, Middle Initial), if not retiree	YOUR SOCIAL SECURITY NUMBER

SEX ☐ M ☐ F	DATE OF BIRTH (Mo/Dy/Year)	REQUESTED EFFECTIVE DATE (Mo/Dy/Year)

CONTACT PHONE	EMAIL ADDRESS

PERMANENT RESIDENCE (Number, Street) **(No P.O. boxes accepted by Medicare)**

(City, State, ZIP)

MAILING ADDRESS (Number, Street) (only if different than your permanent address, P.O. Box accepted)

(City, State, ZIP)

Check plan you are requesting:

☐ UC Medicare PPO Plan

☐ UC High Option Supplement to Medicare Plan

MEDICARE INSURANCE CARD

Please complete the Medicare card below AND send a copy of your card with this form, if available. UC needs your Medicare number and Part A and B Start Dates to enroll you. Call Social Security to obtain this information as needed.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name _____

Medicare Number

_____

Is Entitled To	Coverage Start Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

QUESTIONS

1. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or state pharmaceutical assistance programs.

   Will you have other **prescription** drug coverage? ☐ Yes ☐ No

   If yes, please list your other coverage and your identification (ID) number(s) for this coverage.

   Name of other coverage: _____

   ID # for Coverage: _____

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If yes, provide the Institution name, address and phone number:

   Name:_____

   Address (number and street):_____

   Phone Number: _____

WHITE: RASC
YELLOW: MEMBER COPY

TERMS & CONDITIONS MUST BE ACCEPTED AND THIS FORM SIGNED TO BE ENROLLED. INCOMPLETE FORMS WILL NOT BE PROCESSED.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer**

Please contact the health plan if you would prefer to receive information in a language other than English or in another format.

ARBITRATION

With the exception of benefits provided or administered by Optum Behavioral Health, UC-sponsored medical plans require resolution of disputes through arbitration.

With regard to each plan, by your written or electronic signature, IT IS UNDERSTOOD AND YOU AGREE 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.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

☐ **By checking this box I am signing and accepting the above arbitration terms PERTAINING TO THIS MEDICAL PLAN.**

SIGNATURE	
ENROLLEE SIGNATURE (Electronic signatures, e.g., Adobe, DocuSign or Microsoft signatures, are accepted; not typed))	DATE

If you are the authorized representative (i.e., power of attorney or legal guardian—see description on page 4), you must provide the following information.

NAME	ADDRESS
PHONE NUMBER	RELATIONSHIP TO ENROLLEE

WHITE: RASC
YELLOW: MEMBER COPY

ARBITRATION TERMS & CONDITIONS MUST BE CHECKED AND THIS FORM SIGNED TO BE ENROLLED. INCOMPLETE FORMS WILL NOT BE PROCESSED.

YOUR SIGNATURE INDICATES YOU HAVE READ AND AGREE TO THE FOLLOWING IMPORTANT INFORMATION

If you are a member of a Medicare Advantage plan (like an HMO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By enrolling in the UC Medicare Prescription Drug Plan, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage plan or UC's Retirement Administration Service Center at:

800-888-8267 (in the U.S.)
510-987-0200 (outside the U.S.)
Monday–Friday, 8:30 a.m.–4:30 p.m. PST

If you currently have health coverage from another employer or union, joining a UC Medicare Prescription Drug Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join UC Medicare Prescription Drug Plans. Read the communications your employer or union send you. If you have questions, visit their website, or contact the office listed in their communications.

By completing this enrollment application, I agree to the following:

The UC Medicare Prescription Drug Plan is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and Part B coverage.

It is my responsibility to inform the UC Medicare Prescription Drug Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at any time. If I am currently in another Medicare Prescription Drug Plan, my enrollment in the UC Medicare Prescription Drug Plan will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available (for example, during your former employer group/union's open enrollment period or during the Medicare Annual Enrollment Period, from October 15 through December 7), unless I qualify for certain special circumstances.

The UC Medicare Prescription Drug Plan serves a specific service area. If I move out of the area that the UC Medicare Prescription Drug Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use UC Medicare Prescription Drug Plan network pharmacies. Once I am a member of the UC Medicare Prescription Drug Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from UC Medicare Prescription Drug Plan when I get it to know which rules I must follow to get coverage.

I understand that I if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good a Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the State Medicaid program and the Medicare Savings Program.

Release of information

By joining this Medicare Prescription Drug Plan, I acknowledge that the University of California and UC Medicare Prescription Drug Plan will release my information to Medicare or other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that the University of California and UC Medicare Prescription Drug Plan will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment, and 2) documentation of this authority has been filed with the University of California and is available upon request by Medicare.