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

UBEN 100 (R10/21) University of California Human Resources

Mail completed form to: RASC
P.O. Box 24570
Oakland, CA 94623-1570
Fax to: 800-792-5178

For help with this form, 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/campus-contacts.html. Print clearly or type using UCnet online form, sign page 2 (no typed signature) and fax/mail.

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

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	FORMER CAMPUS/LAB LOCATION	RETIREMENT SYSTEM COVERAGE ☐ UCRP ☐ CalPERS ☐ OTHER (Specify):
HOME ADDRESS (Number, Street, City, State, ZIP) ☐ **NEW**	MAILING ADDRESS (Number, Street, City, State, ZIP) ☐ **NEW**		EMAIL (To save go to retirementatyourservice.ucop.edu)

2. ACTION REQUESTED Select event here and plan(s) in Section 3.

ENROLL (documentation will be requested/verified through UC's vendor UnifyHR)
- ☐ Spouse (date of marriage: _____)
- ☐ Domestic partner (enrollment of a domestic partner in your medical or dental plan and successful completion of the Family Member Verification process automatically names them as your UCRP survivor, if eligible)
  - • Registered with State of CA (filing date: _____)
  - • Not registered with State of CA (date partnership began: _____)
- ☐ New survivor (member date of death: _____)
- ☐ Late enrollment—medical only (90-day delayed effective date: _____)
- ☐ Involuntary loss of coverage—attach proof (loss of coverage date: _____)
- ☐ Other (explain in Comments below)

CANCEL/DE-ENROLL*
- ☐ 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/Via Benefits
- ☐ 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: _____)
- ☐ Return to plan's service area (date: _____)
  (Check medical plan enrolled in prior to your move.)
- ☐ Medicare plan not available/provider group disruption
- ☐ Transfer plans into retirement (retirement date: _____)
- ☐ Transfer plans to UCRP disability
- ☐ Other (explain in Comments box below)

*For Kaiser Senior Advantage members, also submit form UBEN 101

Comments:

MEDICARE—Complete below and send a copy of each member's Medicare card with this form.

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

3. YOUR MEDICAL, DENTAL, LEGAL PLAN To de-enroll from your current UC plan and enroll in another UC plan, check "cancel." To de-enroll from your current UC plan and enroll in a non-UC plan, check "suspend."

MEDICARE MEDICAL PLANS

	ENROLL	CANCEL	SUSPEND
UC Medicare Choice	☐	☐	☐
Kaiser Senior Advantage[1]	☐	☐	☐
UC Medicare PPO	☐	☐	☐
UC High Option Supplement to Medicare[4]	☐	☐	☐
UC Medicare PPO without Rx[2, 4]	☐	☐	☐
Via Benefits–Medicare Coordinator Prog[3, 4]	☐	☐	☐

NON-MEDICARE MEDICAL PLANS

	ENROLL	CANCEL	SUSPEND
UC Blue & Gold HMO[1]	☐	☐	☐
Kaiser–CA[1]	☐	☐	☐
UC Care	☐	☐	☐
UC Health Savings Plan	☐	☐	☐
CORE	☐	☐	☐

DENTAL PLAN

	ENROLL	CANCEL	SUSPEND
Delta Dental PPO	☐	☐	☐
DeltaCare® USA (CA residents only)	☐	☐	☐

LEGAL PLAN

	ENROLL	CANCEL
ARAG Legal Plan	☐	☐

1 Must live in plan's service area 2 Must send proof of other Medicare Part D coverage 3 Must live outside of CA 4 All covered members must be enrolled in Medicare

4. FAMILY MEMBER INFORMATION List all eligible family members referred to in Section 2.

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

Eligible children: C – Child (biological or adopted); P – Stepchild; N – Overage disabled child[5]; W – Legal ward[7]; K – Domestic partner's grandchild[6] or child[8]; G – Grandchild[6]

5 Must be a tax dependent of retiree or spouse/domestic partner unless SSI exception applies
6 Must be a tax dependent of retiree or spouse/domestic partner
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."

Family Member Name (Last, First, MI)	Sex	Relationship Code (see above)	Birthdate MONTH DAY YEAR	Social Security Number (required)	Action: Medical	Action: Dental	Action: Legal
1.					☐ Enroll ☐ Cancel/de-enroll	☐ Enroll ☐ Cancel/de-enroll	☐ Enroll ☐ Cancel/de-enroll
2.					☐ Enroll ☐ Cancel/de-enroll	☐ Enroll ☐ Cancel/de-enroll	☐ Enroll ☐ Cancel/de-enroll

Please retain this UBEN 100 document as part of your UC records.

SEE PAGE 2—TERMS & CONDITIONS MUST BE ACCEPTED AND THIS FORM MUST BE SIGNED TO BE ENROLLED. INCOMPLETE FORMS WILL NOT BE PROCESSED.

PARTICIPATION TERMS AND CONDITIONS

Your Social Security number, and that of your enrolled family members, is required for purposes of benefit plan administration, for financial reporting, to verify your identity, and for legally required reporting purposes all in compliance with federal and state laws.

If you are confirmed as eligible for participation in UC-sponsored plans, you are subject to the following terms and conditions:

ARBITRATION—FOR NON-KAISER MEMBERS

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 ALL MEDICAL PLANS EXCEPT KAISER FOUNDATION HEALTH PLANS and OPTUM BEHAVIORAL HEALTH.**

ARBITRATION—FOR KAISER MEMBERS

With regard to enrollment in a Kaiser Foundation Health Plan (KFHP), I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc., any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

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 KAISER FOUNDATION HEALTH PLANS.**

For more information about each plan's arbitration provision please see the appropriate plan booklet or call the plan.

1. UC and UC health and welfare plan vendors comply with federal/state regulations related to the privacy of personal/confidential information including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as applicable. To fulfill the responsibilities and perform the service required under contracts with UC, 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.
2. 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)/ designated bank account(direct payment 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.
3. 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.
4. 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.
5. 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.
6. 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; for purposes of COBRA, eligibility loss notice must 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).
7. 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. Employees/retirees may also be subject to disciplinary action and de-enrollment from health benefits and may be responsible for any cost of benefits provided and UC-paid premiums due to misuse of plan.
8. Under current state and federal tax laws, the value of the contribution UC makes toward the cost of health coverage provided to domestic partners and certain other 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. (Coverage provided to California registered domestic partners is not subject to imputed income for California state tax purposes.)
9. 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), you may be required to sign an authorization allowing UC to provide the health plan with relevant protected health information or authorizing the health plan to release such information to the University representative.
10. 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.

5. SIGNATURE: I have read, understand and accept the "Participation Terms and Conditions" on this form. I certify under penalty of perjury that the information I provided is true to the best of my knowledge.

SIGNATURE OF RETIREE, SURVIVOR OR DISABLED MEMBER (Electronic signatures, e.g., Adobe, DocuSign or Microsoft signatures, are acceptable; not typed.)	DATE	DAYTIME PHONE ☐ NEW
		( )

Please retain this UBEN 100 document as part of your UC records.

WHITE: RASC
YELLOW: RETIREE COPY

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) 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, in addition to 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, 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 UC medical coverage becomes effective and employee premiums may need to be paid on an after-tax basis (retiree premiums are always paid after-tax). The 90-day waiting period does not apply to those eligible for the Medicare Coordinator Program. Otherwise, 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 (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.

In addition to the special enrollment rights you have under HIPAA, the University's Group Insurance Regulations (GIRs) permit you to change medical plans under certain other conditions. See UC GIRs for additional detail.

*** 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 (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 (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 and Programs, 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.