

**NOTICE OF EMPLOYEE COBRA QUALIFYING EVENT**  
**UBEN 109A (R5/09) UCD Benefits**

Submit this form to your Employee Benefits office after updating the online system.

For certain types of COBRA qualifying events, the employee's department must submit notification to the Benefits Office within 14 days of the date of the qualifying event or the date the BELI is changed in PPS (from BELI 1, 2, 3 or 4 to BELI 5 or P).

**Use this form to notify the Benefits Office of the occurrence of any of the qualifying events shown below and to request a COBRA application packet for medical, dental and/or vision insurance continuation.**

- **Reduction of Hours** – The employee's 12-month average time reporting (IHRS screen) has been under 17.50 hours per week for two consecutive months.
- **Loss of Eligibility** – The employee has moved into a position that is ineligible for benefits (i.e. casual-restricted, academic titles reserved for students, per diem, by-agreement, without salary)

**Note: Failure to provide notice of these events within the 14-day time limit may result in the department being charged for additional month's premiums.**

Detailed information about COBRA continuation is available on At Your Service, [atyourservice.ucop.edu](http://atyourservice.ucop.edu).

Only qualifying beneficiaries can elect COBRA continuation coverage. A qualified beneficiary is generally a UC employee or family member who is eligible for and enrolled in a UC-sponsored group health plan on the day before the qualifying event.

**Department:** Complete this notice and submit to your Benefits Office within the 14-day period mentioned above. Upon receipt of this notice, the Benefits Office will manually coordinate issuing the COBRA application packet. Provide to employee the following (available on At Your Service, [atyourservice.ucop.edu](http://atyourservice.ucop.edu)):

- COBRA Premium Information
- COBRA Continuation Coverage General Notice

**Employees:** To cancel coverage other than medical, dental, vision and disability, submit an Enrollment, Change, Cancellation, or Opt Out form (UPAY 850; available on the At Your Service website) to your Benefits Office as appropriate –

- **Reduction of Hours** – Your eligibility for participation in the legal, life and accident insurance plans may continue as long as you receive regular earnings which are sufficient to cover required deductions.
- **Loss of Eligibility** – Your eligibility for participation in the legal, life and accident insurance plans end. You must cancel these plans. Coverage may be converted to an individual policy offered by the carrier. Contact your Benefits Office for additional information.

1. EMPLOYEE INFORMATION				
EMPLOYEE NAME (Last, First, Middle Initial)	EMPLOYEE ID #			
2. TYPE OF QUALIFYING EVENT/DATE OF QUALIFYING EVENT				
Indicate the type of COBRA qualifying event	Date of qualifying event			
<input type="checkbox"/> Reduction of Hours – Indicate average hours on PPS (IHRS screen): _____ <input type="checkbox"/> Loss of Eligibility	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; width: 33%; text-align: center;">mm</td> <td style="border-right: 1px solid black; width: 33%; text-align: center;">dd</td> <td style="width: 33%; text-align: center;">yy</td> </tr> </table>	mm	dd	yy
mm	dd	yy		
3. DEPARTMENT SIGNATURE				
DEPARTMENT PERSON PROVIDING NOTICE	DATE			
DEPARTMENT	PHONE			
<b>I acknowledge that I no longer qualify to be enrolled in the UC-sponsored group health, disability and/or dependent care programs.</b>				
EMPLOYEE SIGNATURE	DATE			

Copy to employee, department  
 Original to Benefits Office

**SEE NEXT PAGE FOR PRIVACY NOTIFICATIONS**

## **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 Associate Vice President—University of California Human Resources and Benefits, 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 1X, 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.