HMO MEDICAL PLAN TRANSFER FOR EMPLOYEES

UPAY 898 (1/05) University of California Human Resources and Benefits

Submit this form to your Employee Benefits office.
Shaded areas should be completed by the person updating the online system.
Remember to make a copy of this form for your records.

Use this form to transfer from your current UC California HMO to another UC California HMO medical plan ONLY.
Do not use this form to make any other changes (see UPAY 850)

1. PERSONAL INFORMATION

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	HOME PHONE	EMPLOYEE I.D. NUMBER
MAILING ADDRESS	BIRTHDATE MO / DY / YR	SEX ☐ M ☐ F	CAMPUS AND DEPARTMENT
CITY, STATE, ZIP	CAMPUS/LAB E-MAIL ADDRESS		CAMPUS PHONE

2. EMPLOYEE ACTIONS

To change from your current California HMO to another HMO medical plan listed below, check the cancel box for your existing plan and check the enroll box for your new plan.

Coverage Effective Date For Your New Medical Plan

_____ MO 01 DY _____ YR

MEDICAL

Health Net	☐ Enroll	☐ Cancel
PacifiCare of California	☐ Enroll	☐ Cancel
Kaiser Permanente – CA (North)[1]	☐ Enroll	☐ Cancel
Kaiser Permanente – CA (South)[1]	☐ Enroll	☐ Cancel
Western Health Advantage	☐ Enroll	☐ Cancel

[1]PCPs not required if you enroll in Kaiser, unless you live within Coachella Valley or western Ventura County.

3. PCP/PMG SELECTION FOR YOURSELF AND YOUR CURRENTLY ENROLLED FAMILY MEMBERS

List yourself and all enrolled family members, as well as the appropriate Primary Care Physician ID#.
A relationship code is required for each family member you list below.

Name (Last, First, MI)	Sex M/F	Relationship Code*	Birthdate	Primary Care Physician Name & ID#
		Employee	MO | DY | YR	
			MO | DY | YR	
			MO | DY | YR	
			MO | DY | YR	
			MO | DY | YR	

* RELATIONSHIP CODES: S: Legal Spouse A: Adult Dependent Relative (enrolled before 01/01/04) D: Same-Sex Domestic Partner L: Opposite-Sex Domestic Partner
C: Natural/Adopted Child P: Stepchild G: Grandchild K: Partner's Child/Grandchild W: Legal Ward O: Other Child (enrolled before 09/01/94)
N: Non-tax dependent Overage Child

Signature: I have read the Employee Checklist and agree to the "Terms and Conditions" outlined on the back of this form. All or the above information is true to the best of my knowledge.

EMPLOYEE'S SIGNATURE	DATE	SYSTEM UPDATED BY	DATE

ORIGINAL: BENEFITS
COPY: MEDICAL CARRIER
COPY: EMPLOYEE

SEE REVERSE FOR PRIVACY NOTIFICATIONS

TERMS AND CONDITIONS

The medical plans that UC offers (except PacifiCare of Nevada) require resolution of medical malpractice and other disputes through binding arbitration. When you select one of these plans, you agree that any disputes between you (and/or your enrolled family members) and the medical plan must be submitted to binding arbitration. You agree to give up your right to a jury or court trial to resolve these disputes. For more information about each plan's arbitration provision, please see the appropriate plan booklet.

You understand and accept the relevant terms and conditions of the UC-sponsored plans in which you are enrolled as stated in the plan booklets and UC's Group Insurance Regulations.

If you enroll family members, the University may require proof of eligibility-marriage or birth certificates, adoption papers, tax records, and the like. You agree to provide such documentation upon request. If you do not provide documentation when requested, you understand that your family member(s) will be deenrolled retroactively and you will be liable for all costs incurred as a result of the invalid enrollment.

If you enroll an eligible family member who is not a tax dependent, you understand that the value of the UC/employer contribution for medical and/or dental coverage for these individuals may be considered taxable income to you and may be subject to FICA (Social Security and Medicare) and income tax withholding.

When you specifically ask UC representatives to intercede on your behalf with your insurance plan, you authorize the plan to release to the UC representatives copies of all relevant records pertaining to you and/or your family member(s), as appropriate. You also authorize UC to provide the insurance plan with any relevant personal health information.

You authorize deductions from your monthly benefits to cover your premium share, if any, for the plans you have chosen for yourself and your eligible family members. This authorization will remain in effect until you change or cancel coverage.

You certify that all the information you provide is true to the best of your knowledge, under penalty of perjury.

CONTINUATION PRIVILEGES

For legal spouse, natural or adopted child, stepchild, legal ward, other child, and/or grandchild

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued plan coverage for a certain period of time at specified monthly rates if you or your eligible family members lose group medical, dental, or vision coverage because you die, divorce, or are legally separated, or because a child ceases to be eligible. Call your Benefits Office for more information.

For adult dependent relative, same-sex domestic partner, partner's child/grandchild

While not required under COBRA, UC's health carriers have agreed to provide continuation coverage for an eligible adult dependent relative, a same-sex domestic partner, or a partner's child/grandchild. Coverage may continue for a certain specified period of time at specified monthly rates if you or your eligible family members lose group medical, dental, or vision coverage because you die, because your relationship with an adult dependent relative or a same-sex domestic partnership ends, or because an adult dependent relative or a partner's child/grandchild is no longer eligible for coverage. Call your Benefits Office for more information.

WHEN ELIGIBILITY ENDS

For adult dependent relatives, same-sex domestic partners, partner's child/grandchild

UC-sponsored group insurance coverage stops at the end of the month in which an adult dependent relative, same-sex domestic partner, or a partner's child/grandchild is no longer eligible. **UC requires the employee to provide the adult dependent relative or the same-sex domestic partner with a copy of the cancellation form.** For medical, dental, and vision plan continuation coverage, the adult dependent relative or same-sex domestic partner should call the employee's Benefits Office.

HIPAA (Health Insurance Portability and Accountability Act of 1996) Notification of Medical Program Eligibility

You may decline enrollment for yourself and/or your eligible family members because you have other medical insurance coverage. If you lose that coverage in the future, you may be able to enroll in a UC-sponsored medical plan. You must request enrollment within 31 days after the other coverage ends. If you are not enrolled in a UC-sponsored medical plan, and you have a newly eligible family member as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible family member(s). You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you do not enroll within the 31 days when you are first eligible, you may enroll at a later date. However, you will need to complete a waiting period of 90 consecutive calendar days before your medical coverage is effective, or you must wait until the next Open Enrollment period to enroll.

PRIVACY NOTIFICATIONS

STATE

The State of California Information Practices 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 the information on this form is for payment of earnings and for miscellaneous payroll and personnel matters, such as, but not limited to, withholding taxes, benefits administration, and changes in title and pay status. University policies 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 used by various University departments for payroll and personnel administration and will be transmitted to the federal and state governments as 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 officials responsible for maintaining the information contained on this form are Office of the President and campus Academic and Staff Personnel Managers or campus Accounting Officers.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. Disclosure of the Social Security number is required pursuant to sections 6011 and 6051 of Subtitle F of the Internal Revenue Code and with Regulations 4, Section 404.1256, Code of Federal Regulations under Section 218, Title II of the Social Security Act, as amended. The Social Security number is used to verify your identity. The principal uses of the number shall be to report (1) state and federal income taxes withheld, (2) Social Security contributions, (3) state unemployment and Worker's Compensation earnings, (4) earnings and contributions to participating retirement systems, and (5) as an identifier for your insurance carrier to verify your eligibility and maintain claim records for you and your eligible family members.