ENROLLMENT, CHANGE, CANCELLATION, OR OPT OUT—EMPLOYEES ONLY

HEALTH AND WELFARE PLANS

UPAY (R1007) University of California Human Resources and Benefits

Use this form to enroll in, change, cancel, or opt out of insurance plans for yourself and/or your eligible family members. For complete information on eligibility, effective dates, and allowable actions, see Your Group Insurance Plans, available on the At Your Service website (atyourservice.ucop.edu) or from your department or Benefits Office.

1. If the only action you require is to enroll or de-enroll coverage for a family member, you must complete Sections 1, 2, and 5. List only the eligible family member(s) you wish to enroll or de-enroll, or for whom you are changing personal data. Current enrollments will remain in effect until you notify UC of a change, subject to payroll deadlines. If you are changing plans, complete Sections 1 and 3 only; your enrolled family members will change plans automatically. Please note that you may only enroll your eligible family members in the plans in which you are enrolled.

2. To name your beneficiaries for the Supplemental Life and AD&D plans, go online (atyourservice.ucop.edu; select “Sign in to My Accounts” and “My Beneficiaries”) or use form UBEN 716. You are automatically the beneficiary of a family member under the Expanded Dependent Life and/or AD&D insurance plans. To designate a different beneficiary, use form UBEN 119.

PARTICIPATION TERMS AND CONDITIONS

Your Social Security number will be requested only when needed by benefit plan administration for financial reporting or to verify your identity, in compliance with state and federal law.

As a participant in UC-sponsored plans, you agree to the following terms and conditions:

1. You will not be required to enroll in the medical plans that UC offers (including the medical portion of Blue Cross Plus and Blue Cross PPO (offered by Blue Cross of California)‡, Health Net, Western Health Advantage, and CIGNA Choice Fund), Core (offered by BC Life & Health Insurance Company), Health Net Permanent, and the University of California’s third-party health plan specified in the plan booklets or UC’s Group Insurance Regulations. You are required to enroll in the UC-sponsored medical plans for state income tax reporting. University policy and state and federal statutes authorize the maintenance of this information.

2. You are automatically the beneficiary of a family member under the Expanded Dependent Life and/or AD&D insurance plans. To designate a different beneficiary, use form UBEN 716. You are automatically the beneficiary of a family member under the Expanded Dependent Life and/or AD&D insurance plans. To designate a different beneficiary, use form UBEN 119.

3. You acknowledge and accept all 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.

4. If you enrol family members, the University and/or carrier may require proof of eligibility. Marriage or birth certificates, adoption certificates, tax records, and the like may be required. You agree to provide such documentation upon request.

5. If you enrol your eligible domestic partner and/or your partner’s eligible child(ren) or grandchild(ren), or if you enrol or have enrolled your natural or adopted child who is not claimed as your tax dependent, you acknowledge that the UC/employer contribution for their medical and dental coverage may be considered your taxable income, subject to FICA (Social Security and Medicare) and federal and California state income tax withholding.

6. If you specifically ask UC representatives to intercede on your behalf with your insurance plan, University representatives will request minimum necessary health information related to your problem, in compliance with state privacy laws and federal 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 personal health information or authorization to release such information to the University representative.

7. Actions you take during Open Enrollment will be effective the following January 1, unless otherwise stated.

NOTES:

* An adult dependent relative is eligible to continue UC-sponsored medical, dental, and/or vision coverage if enrolled by December 31, 2003, and coverage is continuous.

** Your adult dependent relative must not be eligible for Medicare Part A.

† Blue Cross of California® and BC Life & Health Insurance Company are independent licensees of the Blue Cross Association. The Blue Cross name and symbol are registered service marks of the Blue Cross Association.

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 eligible 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 that other coverage for you or your family members). You must request enrollment within 31 days after you or your family member loses other coverage (or if the employer stops contributing toward the other coverage).

In addition, if you have a newly eligible family member as a result of marriage/domestic partnership, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and your eligible family member(s). You must request enrollment within 31 days after the marriage/domestic partnership, birth, adoption, or placement for adoption.

If you do not enrol yourself and/or your eligible family member(s) within the 31 days when first eligible, you may enrol at a later date. However, each member will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective, or you/them can enrol during the next Open Enrollment Period.

To request special enrolment or obtain more information, contact your local Benefits Office.

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;

• your eligible family member loses coverage.

In either case, you must request enrolment within 31 days of the occurrence.

** To be eligible for plan membership you and your family members must meet all UC eligibility requirements for coverage as stated in the Group Insurance Eligibility Factsheet. All plan members are subject, as a condition of coverage, to eligibility verification audit by the University and/or insurance carriers.

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 this information, 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, Suite 610, Oakland, CA 94612.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. For complete information on eligibility, effective dates, and allowable actions, see Your Group Insurance Plans, available on the At Your Service website (atyourservice.ucop.edu) or from your department or Benefits Office.
ENROLLMENT, CHANGE, CANCELLATION, OR OPT OUT—EMPLOYEES ONLY

Use this form to enroll in, change, cancel, or opt out of insurance plans for yourself and/or your eligible family members. For complete information on eligibility, effective dates, and allowable actions, see Your Group Insurance Plans, available on the At Your Service website (atyourservice.ucop.edu) or from your department or Benefits Office.

If the only action you require is to enroll or de-enroll coverage for a family member, you must complete Sections 1, 2, and 5. List only the eligible family member(s) you wish to enroll or de-enroll, or for whom you are changing personal data. Current enrollments will remain in effect until you notify UC of a change, subject to payroll deadlines. If you are changing plans, complete Sections 1 and 3 only; your enrolled family members will change plans automatically. Please note that you may only enroll your eligible family members in the plans in which you are enrolled.

To name your beneficiaries for the Supplemental Life and AD&D plans, go online (atyourservice.ucop.edu; select “Sign in to My Accounts” and “My Beneficiaries”) or use form UBEN 716. You are automatically the beneficiary of a family member under the Expanded Dependent Life and/or AD&D insurance plans. To designate a different beneficiary, use form UBEN 119.

PARTICIPATION TERMS AND CONDITIONS

Your Social Security number will be requested only when needed by benefit plan administration for financial reporting or to verify your identity, in compliance with state and federal law. As a participant in UC-sponsored plans, you agree to the following terms and conditions:

1. If you enroll in the medical plans that UC offers (including the medical portion of Blue Cross PLUS and Blue Cross PPO (offered by Blue Cross of California®), UC Health Net, Western Health Advantage, and CIGNA Choice Fund), Core (offered by BC Life & Health Insurance Company), UCare, the UnitedHealthcare Plum Plan, and the Blue Cross (offered by Blue Cross of California®) (formerly UC Health Plan), you must complete Section 3 and 4 to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective, or you/they can enroll during the next Open Enrollment Period.

2. If you do not enroll yourself and/or your eligible family member(s) within the 31 days when first eligible, you may enroll at a later date.

3. If the only action you require is to enroll or de-enroll coverage for a family member, you must complete Sections 1, 2, and 5. List only the eligible family member(s) you wish to enroll or de-enroll, or for whom you are changing personal data. Current enrollments will remain in effect until you notify UC of a change, subject to payroll deadlines. If you are changing plans, complete Sections 1 and 3 only; your enrolled family members will change plans automatically. Please note that you may only enroll your eligible family members in the plans in which you are enrolled.

4. To request special enrollment or obtaining more information, contact your local Benefits Office.

5. If you enroll your eligible domestic partner and/or your eligible child(ren) or grandchild(ren), or if you enroll or have enrolled your natural or adopted child who is not claimed as your tax dependent, you acknowledge that the UC/employer contribution for their medical and/or dental coverage may be considered your taxable income, subject to FICA (Social Security and Medicare) and federal and California state income tax withholding.

6. If you specifically ask UC representatives to intercede on your behalf with your insurance plan, University representatives will request minimum necessary health information related to your request with your consent. If more protected health information is involved in solving your problem, in compliance with state privacy laws and federal 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 personal health information or authorization to release such information to the University representative.

7. Actions you take during Open Enrollment will be effective the following January 1, unless otherwise stated.

8. You certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in the UC publications, Group Insurance Eligibility Fact sheet for Employees and Eligible Family Members, and the Group Insurance Eligibility Fact sheet for Retirees and Eligible Family Members. You agree that you will de-enroll them within 31 days if they lose eligibility. You further certify that all the information you provide is true to the best of your knowledge, under penalty of perjury.

9. Making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility, or enrolling 31 days after the 31 days of such loss, will result in de-enrollment of the family member and possible legal action. In addition, employees/retirees may be subject to disciplinary action (e.g., loss of health benefits for up to 12 months) and will be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage.

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 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 domestic partner, partner’s child/grandchild, and/or adult dependent relative*

While not required under COBRA, UC’s health carriers have agreed to provide continuation coverage for an eligible domestic partner, and/or a partner’s child/grandchild, or an adult dependent relative enrolled by 12/31/03. Coverage may continue for a certain period of time at 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.

WHEN ELIGIBILITY ENDS

For domestic partner, partner’s child/grandchild, and/or adult dependent relative*

Unless continuation coverage is elected, UC-sponsored group insurance coverage stops at the end of the month the dependent is no longer eligible. UC requires the employee to provide the domestic partner or the adult dependent relative with a copy of this cancellation form. For medical, dental, or vision plan continuation coverage, the domestic partner or adult dependent relative should call the employee’s Benefits Office.

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 member(s)** 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 your 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/domestic partnership, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and your eligible family member(s). You must request enrollment within 31 days after the marriage/domestic partnership, birth, adoption, or placement for adoption.

If you do not enroll yourself and/or your eligible family member(s) within the 31 days when first eligible, you may enroll at a later date. However, each member will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective, or you/them can enroll during the next Open Enrollment Period.

*NOTE: An adult dependent relative is eligible to continue UC-sponsored medical, dental, and/or vision coverage if enrolled by December 31, 2003, and coverage is continuous.

† Your adult dependent relative must not be eligible for Medicare Part A.

‡ Blue Cross of California® and BC Life & Health Insurance Company are independent licensees of the Blue Cross Association. The Blue Cross name and symbol are registered service marks of the Blue Cross Association.

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, Personal and Family Services.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory to the University. Your 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, 6012 and 6059) reporting, and/or for benefits administration, and/or to verify your identity.

* **To be eligible for plan membership you and your family members must meet all UC eligibility requirements for coverage as stated in the Group Insurance Eligibility Factsheet. All plan members are subject, as a condition of coverage, to eligibility verification audit by the University and/or insurance carriers.

† Blue Cross of California® and BC Life & Health Insurance Company are independent licensees of the Blue Cross Association. The Blue Cross name and symbol are registered service marks of the Blue Cross Association.

‡ The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued plan coverage for a certain period of time at 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.

§ UC requires the employee to request enrollment within 31 days after the marriage/domestic partnership, birth, adoption, or placement for adoption.

¶ University representatives will request minimum necessary health information related to your request with your consent. If more protected health information is involved, University representatives will request minimum necessary health information related to your request with your consent. If more protected health information is involved,
1. PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Name (Last, First, Middle)</th>
<th>Social Security Number</th>
<th>Campus/Dental Department</th>
<th>Campus/Dental Phone</th>
<th>Employee ID No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. EMPLOYEE ACTIONS

<table>
<thead>
<tr>
<th>TYPE OF ACTION OR QUALIFYING EVENT (check all that apply):</th>
<th>WRITE IN DATE OF EVENT, if applicable.</th>
<th>MOVE OUT OF UC’s plan service area (date: ____________________________).</th>
<th>STATEMENT OF HEALTH (Life/Disability only):</th>
<th>PREVIOUS EMPLOYERS (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>取消 保険の適用日 (日付: ____________________________).</td>
<td>取消できる保険の適用日 (日付: ____________________________).</td>
<td>以前の雇用者 (チェックすべて適用):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reasons:</td>
<td>取消原因:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Divorce, legal separation, annulment</td>
<td>离婚、法律上の離婚、解消:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Termination of partnership registered with the State of California (filing date of termination)</td>
<td>パートナーシップの終了が州法律に基づいて登録された場合 (中止日):</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>termination of partnership not registered with the State of California (date relationship ended)</td>
<td>パートナーシップの終了が州法律に基づいて登録されていない場合 (関係終了日):</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Loss of eligibility for adult dependent relative</td>
<td>失効分のための成人法定親 (認可):</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other (provide reason in comments box below)</td>
<td>その他 (理由をコメント欄に記入):</td>
<td></td>
</tr>
</tbody>
</table>

3. MEDICAL, DENTAL, VISION, AND LEGAL

<table>
<thead>
<tr>
<th>Health Net</th>
<th>Kaiser—CA</th>
<th>Western Health Advantage</th>
<th>Core</th>
<th>Blue Cross PLUS</th>
<th>Blue Cross PPO</th>
<th>CIGNA Choice Fund</th>
<th>Other:</th>
</tr>
</thead>
</table>

4. OTHER INSURANCE PLANS—SEE FORM INTRODUCTION FOR INFORMATION ON NAMING BENEFICIARIES FOR LIFE INSURANCE AND AD&D PLANS

<table>
<thead>
<tr>
<th>Employee only</th>
<th>SUPPLEMENTAL DISABILITY</th>
<th>SUPPLEMENTAL LIFE</th>
<th>DEPENDENT LIFE</th>
<th>ACCIDENTAL DEATH &amp; DISMEMBERMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coverage Effective Date</td>
<td>Coverage Effective Date</td>
<td>Coverage Effective Date</td>
<td>Coverage Effective Date</td>
</tr>
<tr>
<td></td>
<td>MO</td>
<td>DY</td>
<td>VR</td>
<td>MO</td>
</tr>
</tbody>
</table>

5. ADDITIONAL EMPLOYEE INFORMATION AND ELIGIBLE FAMILY MEMBER ACTIONS

<table>
<thead>
<tr>
<th>Action</th>
<th>Date of Event</th>
<th>Name (Last, First, Mi)</th>
<th>Sex</th>
<th>Relationship</th>
<th>Birthdate</th>
<th>Social Security Number (required)</th>
<th>Med/Dent</th>
<th>Vis</th>
<th>Leg</th>
<th>Primary Care Physician</th>
<th>Medical Group I.D.</th>
<th>Check Current Coverage Date</th>
</tr>
</thead>
</table>

My signature below indicates I have read and agree to the “Terms and Conditions” on the back of this form. I declare under penalty of perjury that all of the above information is true to the best of my knowledge.

<table>
<thead>
<tr>
<th>EMPLOYEE’S SIGNATURE</th>
<th>DATE</th>
<th>OTHER EMPLOYEE’ SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

If you were enrolled in the plan(s) and your family member(s) were enrolled in the plan(s) and specifying the date coverage ends.)

(You may not cancel vision coverage, due to internal procedures. However, you may opt out of vision coverage, see section 2A, above.)

Return from leave/furlough (date: ________________).

Change personal data for eligible family member (date: ________________). Reason: ____________________________.
ENROLLMENT, CHANGE, CANCELLATION, OR OPT OUT—EMPLOYEES ONLY

1. PERSONAL INFORMATION
   NAME (Last, First, Middle initial) __________________________
   SOCIAL SECURITY NUMBER __________________________
   CAMPUS/LAB AND DEPARTMENT __________________________
   CAMPUS/LAB PHONE __________________________
   EMPLOYEE ID NO. __________________________