UCSF RESIDENTS AND CLINICAL FELLOWS
"INSURANCE ACTION FORM"

Enrollee: Retain a file copy and return completed form to your Departmental Residents/Clinical Fellows Coordinator, within 31 days of Qualifying Event
Department Coordinator: Retain a copy and enter enrollment in GME Insurance Database

1. QUALIFYING EVENT: *Check All appropriate boxes:*

QUALIFYING EVENT DATE: ______________________

New Enrollment:	☐ New Hire	☐ Rehire	☐ Involuntary Loss of Coverage (Cancel Previous Opt-Out Request)	☐ Other
Opt Out:	☐ Enrolled in other UC sponsored coverage		☐ Enrolled in other coverage-Non-UC	☐ Other
Open Enrollment: (June 1st – July 31st with an Effective date of July 1st)			☐ Add Dependent(s)	☐ Change Plans
Cancel Dependent:	☐ Subscriber's Request	☐ Divorce/Legal Sep/End of Partnership		☐ Other
Add Dependent:	☐ Birth/Adoption	☐ Marriage/Domestic Partnership	☐ Involuntary Loss of Coverage	☐ Other
Terminate Insurance:	☐ Separation	☐ Transfer to Faculty/Staff Position	☐ Transfer to Postdoc Position	☐ Other
Info/Address Update:	☐ Complete Personal Information In Section Below.	**Comments:**		

2. PLAN SELECTION: *Check the appropriate box:*

	Enroll	Cancel
HEALTH NET Group # 55509D:	☐	☐
BLUE CROSS Group # 175138M004:	☐	☐

BLUE CROSS Requires Monthly Premiums:

☐ Set-up payroll deduction for premium
☐ R/CF pays premium directly to department

$30-Single　　$60-Single + Child(ren)
$60-Self+ Adults　　$90-Family

^Please Note: Employees must Opt-Out in order to be eligible to enroll in benefits in the future. If you Opt Out or Cancel your Medical Insurance you are declining dental/vision/LTD/Life for yourself. If you are canceling a dependent's medical insurance you are also canceling their dental and vision insurance also.

3. PERSONAL INFORMATION: ***This section must be completed for all changes.*** **(Department Coordinator/Contact) Please update address in OLPPS and E*VALUE**

First Name:	M.I.	Last Name:	Social Security Number:	Employee Identification Number (EIN) is Mandatory:
Local Address:			Birth Date (mo/day/yr):	Marital Status:(S, M, DP*):
City, State, Zip:			Home Phone:	Gender:
Department and Unit/Division:	Campus Box:	Campus Phone/Pager:	If Health Net, Enter 10 Digit PCP "Enrollment ID ** Find provider www.healthnet.com	

4. DEPENDENT INFORMATION: Please Note: Added Dependents are effective the first day of the month following the qualifying event.

E = Enroll T = Terminate	If Health Net, Enter 10 Digit PCP "Enrollment ID" **	First Name:	Last Name:	Social Security Number	Birthdate: (mo/day/yr)	Gender: M/F	Relationship: (S/DP; Child)

ADULTS—You may only enroll one eligible adult. Relationship Codes: S – Spouse; D – Same -sex domestic partner; L – Opposite-sex domestic partner
CHILDREN—Enter the relationship code to indicate the family member's relationship to you: C – Child (natural or adopted); P – Stepchild; N – Overage disabled child[1]; K – Same-sex spouse or partner's grandchild[2] or child; G – Grandchild[2]; W – Legal ward[3]

1 Must be a tax dependent of employee or spouse/domestic partner unless SSI exception applies 2 Must be a tax dependent of employee or spouse/domestic partner 3 Must be a tax dependent of employee

*** If enrolling a Domestic Partner please also complete the Declaration of Domestic Partnership Form.**

**** This is optional - if no enrollment code is entered, Health Net will make PCP selection based on your zip code. To find provider and/or enrollment code go to www.healthnet.com and select 'provider search'.**

5. My signature indicates that I have read and agree to the 'Participation Terms and Conditions' on the next pages. I declare under penalty of perjury that all of the above information is true to the best of my knowledge. I have read the Cobra Acknowledgement Form and the ACA Notice. Incomplete forms will not be processed.

Signature: ______________________________ **Date:** ______________________

Dept. Contact Person Name: ______________________ **Box:** __________ **Phone:** __________

Department Use Only
Date Received:
Submitted/Sent:
☐ Online Benefits Database
☐ Via Email
☐ Via Campus Mail/ Fax

INSURANCE ACTION FORM—RESIDENTS/CLINICAL FELLOWS
HEALTH AND WELFARE PLANS
University of California San Francisco Residents/Clinical Fellows Central Insurance Desk

Use this form to enroll in, change, cancel, or opt out of insurance plans for yourself and/or your eligible family members. Please note that you may only enroll your eligible family members in the plans in which you are enrolled. Submit completed form to your Departmental Coordinator.

To name your beneficiaries for the Supplemental Life and AD&D plans, go online (http://ucsfhr.ucsf.edu/index.php/residents/) and print out the Beneficiary Form. Complete and submit to your Departmental Coordinator. If you are a Safe Harbor Defined Contribution Plan member, or enrolled in the UC 403(b) and/or UC 457(b) please log onto the FITSCo website to designate beneficiaries, https://login.fidelity.com/ftgw/Fidelity/NBPart/Login/Init?AuthRedUrl=https://workplaceservices100.fidelity.com/NBHome.html

PARTICIPATION TERMS AND CONDITIONS

I understand and agree that by enrolling with or accepting services from Plan Entities, I and my enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this application and my signature on page 1, indicates that the information entered in this application is complete and true, and I accept these terms.

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

1. If you are receiving pay solely from sources outside the UCSF payroll system, the UC contributions towards benefits coverage for yourself and enrolled dependents is taxable. Please see the 'Taxability Letter' written to Residents and Clinical Fellows, http://ucsfhr.ucsf.edu/files/Taxability%20Letter%20to%20Residents%20Clinical%20Fellows.pdf
2. If you enroll your eligible domestic partner and/or your partner's 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.
3. I understand that I am responsible for a greater portion if not all of the health plan costs when I use a non-participating provider.
4. If applicable, I authorize my employer to deduct from my wages the required dues.
5. I acknowledge that the effective date of coverage is subject to approval by the plan.
6. I acknowledge and understand that health care providers may disclose health information about me or my dependents to plan Entities. Plan Entities may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs.
7. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
8. Actions you take during Open Enrollment will be effective on July 1, unless otherwise stated.
9. You certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in the Evidence of Coverage Booklets and Summary Plan Descriptions. 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.
10. Making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility within 31 days of such loss, or failing to provide documentation when requested will lead to de-enrollment of the family members and possible legal action. In addition, Resident/Clinical Fellow 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.

BINDING ARBITRATION AGREEMENT

HEALTH NET ENROLLEES

Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration. All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this Enrollment Application applies. "Plan Contract" refers to the Health Net of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company Group Policy and Certificate of Insurance.

BINDING ARBITRATION AGREEMENT

ANTHEM BLUE CROSS ENROLLEES

I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from ERISA or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision:
I understand that Anthem Blue Cross require binding arbitration to settle all disputes including but not limited to claims of medical malpractice if the amount in dispute exceeds the jurisdictional limit of the small claims court**.** This means that Anthem Blue Cross/BC Life and I are waiving our rights to a jury trial for both medical malpractice claims and any other disputes. California Health & Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely 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 this 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." Anthem Blue Cross/BC Life and I are also giving up our right to pursue on a class basis any claim or controversy against each other.

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.

For domestic partner and/or partner's child/grandchild*

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. Coverage may continue 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, because your relationship with a domestic partner ends, or because a partner's child/ grandchild is no longer eligible for coverage.

WHEN ELIGIBILITY ENDS

Unless continuation coverage is elected, UC-sponsored group insurance coverage stops the end of the day the subscriber and/or dependent(s) is no longer eligible. ***For domestic partner and/or partner's child/grandchild,*** when coverage is cancelled, UC requires the Resident/Clinical Fellow provide the domestic partner a copy of this cancellation form. To elect COBRA coverage the domestic partner should call the Departmental Coordinator.

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 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 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/partnership, birth, adoption, or placement for adoption.

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.

To be eligible for plan membership you and your family members must meet all UC eligibility requirements for coverage as stated in the Evidence of Coverage Booklets and Summary Plan Descriptions**.** All plan members are subject, as a condition of coverage, to eligibility verification audit by the 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 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 Graduate Medical Education Office, http://medschool.ucsf.edu/gme/ .

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.