

**UCSF RESIDENTS AND CLINICAL FELLOWS**  
**"INSURANCE ACTION FORM" Effective July 1, 2018**

*Enrollee: Retain a file copy and return completed form to Program Administrator, within 31 days of Qualifying Event*

*Program Administrator: 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 1<sup>st</sup> – June 30<sup>th</sup> with an Effective date of July 1<sup>st</sup>)  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

**Address Update:**  Complete Personal Information In Section Below. **Comments:** \_\_\_\_\_

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

HMO – ANTHEM  Enroll  Cancel

BLUE CROSS

PPO – ANTHEM  Enroll  Cancel

BLUE CROSS

PPO – BLUE CROSS Requires Monthly Premiums:  
 Set-up payroll deduction for premium  
 R/CF pays premium directly to department

\$30-Self                      \$60-Self + Child(ren)  
 \$60-Self + Adult            \$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. If you are canceling a dependent's medical insurance, you are also canceling their dental and vision insurance.

**3. PERSONAL INFORMATION:** *This section must be completed for all changes.*

**(Program Administrator/Contact) Please update address in OLPPS and MedHub**

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 HMO – Anthem Blue Cross Enter 6 Digit PCP "Enrollment ID" ** Find provider <a href="http://www.anthem.com">www.anthem.com</a>	

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

E = Enroll T = Terminate	If HMO – Blue Cross, Enter 6 Digit PCP "Enrollment ID" **	First Name:	Last Name:	Social Security Number	Birthdate: (mo/day/yr)	Gender:	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 child1;  
 K – Same-sex spouse or partner's grandchild2 or child; G – Grandchild2; W – Legal ward3

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 the HMO – Anthem Blue Cross plan will make PCP selection based on your zip code.** To find provider and/or enrollment code go to [www.anthem.com](http://www.anthem.com) and select "Find a Doctor"

**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. Incomplete forms will not be processed.**

Signature: _____	Date: _____	<b>Department Use Only</b>	
_____		Date Received: _____	_____
_____		Submitted/Sent:	_____
_____		<input type="checkbox"/> Online Benefits Database	_____
_____		<input type="checkbox"/> Via Email	_____
_____		<input type="checkbox"/> Via Campus Mail/ Fax	_____

Dept. Contact Person Name: \_\_\_\_\_ Box: \_\_\_\_\_ Phone: \_\_\_\_\_

# 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 <https://www.ucresidentbenefits.com/uc-san-francisco> 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 Fidelity 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, <https://hr.ucsf.edu/hr.php?A=157&AT=cm&org=c>
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

##### REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including 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 incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, 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.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

## **ANTHEM BLUE CROSS ENROLLEES 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.