

# 2012 ENROLLMENT/CHANGE FORM INSTRUCTIONS

Unless there is a Qualifying Life Event, mid-year changes listed below are NOT allowed. If there is a Qualifying Life Event, your change request must be received by HR within 31 days of the event;

- Add or remove yourself or your dependents from your Health and Dental Plans
- Increase or decrease coverage under any Life and AD&D Insurance Plans for you or your dependents. Note: Coverage can be stopped at any time.
- Increase, decrease or stop your account deposits to your Health or Dependent Care Flexible Spending Accounts.

## 1. EMPLOYEE PERSONAL INFORMATION

Complete all requested information.

## 2. VOLUNTARY TERM LIFE INSURANCE

### Employee & Dependent coverage

Indicate the amount of insurance you wish to select. If you are a new enrollee or increasing your current life volume due to a qualifying life event, you must also complete a Sun Life Evidence of Insurability Form which can be obtained at [www.mypacific.myusi.com](http://www.mypacific.myusi.com).

## 3. HEALTH COVERAGE

Select appropriate boxes. If you elect medical coverage, please sign under the appropriate plan in Section 14 on the reverse side of the form. If you waive medical coverage, you must also complete Section 15 Declination of Coverage/Cancellation. Premiums are paid on a pre-tax basis per pay period. If you are covering your spouse/domestic partner you must complete Section 4. If you are covering yourself and/or your dependents, complete Section 6.

## 4. SPOUSE INFORMATION

If you elect to cover your spouse or domestic partner under your medical plan, you **MUST** answer all questions in this section. If the answers to these questions change, you are required to notify HR immediately.

NOTE: If you elect to cover your spouse or domestic partner in any of Pacific's Benefit Plans, you must provide a copy of your marriage or domestic partner certificate.

## 5. DENTAL COVERAGE

Select appropriate boxes. If you are covering your spouse/domestic partner and/or eligible dependents, you must complete Section 6. Delta PPO Plan Premiums are paid on a pre-tax basis per pay period. DeltaCare USA DHMO Plan is a no cost plan for you and your dependents.

## 6. EMPLOYEE & FAMILY INFORMATION

Fill in all requested information for you and your dependents.

Please indicate whether or not your dependents will be enrolled in your Health (medical/vision), Dental Plan and/or Voluntary Life Plans.

Other Coverage- If you check Y indicating that other coverage exists, please complete the Other Coverage information in Section 14.

Anthem Blue Cross Participants-Select a Primary Care Physician

If you enroll in an Anthem Blue Cross HMO or POS plan, they require the designation of a Primary Care Physician (PCP) for you and your covered dependents. You have the right to designate any PCP who participates in their applicable plan network and who is available to accept you or your dependents. For children, you may designate a pediatrician as the PCP. Until you make this designation, Anthem Blue Cross will designate one for you and your covered dependents. For information on how to select a PCP, and for a list of the participating PCPs, please access Anthem Blue Cross on-line Provider Finder at [www.anthem.com/ca](http://www.anthem.com/ca). Once you have selected a PCP, you will need to call Anthem Blue Cross Customer Service to notify them of your selection. Current participants may contact Anthem Blue Cross Customer Service to request to change their PCP.

**DeltaCare USA Participants** If you enroll in the DeltaCare USA DHMO plan, they require the designation of a DeltaCare USA network dentist or facility in the California service area.

You may elect to choose a different DeltaCare USA network dentist or facility in the California service area for you and your covered dependents (limit of up to 3 per family), by contacting Delta Dental. You are able to change your dentist or facility anytime during the year provided you contact Delta Dental by the 15th day of the month, to be effective as late as the 1st of the following month.

For information on how to find a DeltaCare USA network dentist or facility in the California service area, please access Delta Dental's on-line provider finder at [www.deltadentalins.com](http://www.deltadentalins.com).

## 7. HEALTH CARE ACCOUNT (HCA)

## 8. DEPENDENT DAY CARE ACCOUNT (DCA)

*The following is applicable to both HCA and DCA unless otherwise noted.*

Indicate the annual amount of pre-tax dollars you would like deposited to your HCA and/or DCA for expected expenses. The annual maximum amount you can deposit to each of your accounts is \$5,000 (DCA ONLY: \$2,500 if married & filing separate tax returns). No minimum deposits.

**UNUSED** contributions are automatically forfeited at the end of the plan year—"Use It, Don't Lose It."

**DCA ONLY:** The maximum reimbursement is based on you or your spouse's annual earned income. (Certain limitations apply to spouses who are full-time students or are physically or mentally incapable of caring for themselves. Contact Benefits Administrator for more information.)

Social Security benefits may be reduced by this election.

## 9. & 10. TRANSPORTATION MANAGEMENT PROGRAM

Social Security benefits may be reduced by this election.

Transit/Vanpooling and Parking Spending Account(s): Indicate the amount per pay period times the number of remaining pay periods and this will equal the Plan Year total.

Transit/Vanpooling Account: Monthly maximum is \$125.00.

Parking Spending Account (off-site): Monthly maximum is \$240.00\*

*\*San Francisco and Stockton Campus On-Site Parking Receipts will indicate that if a Payroll Deduction payment method is used, the parking fee will be taken on a pre-tax basis. Combined off-site and on-site monthly maximum can not exceed \$240.*

## 11. SUPPLEMENTAL BENEFITS

If interested access Pacific's Benefits Website for additional information. [www.mypacific.myusi.com](http://www.mypacific.myusi.com) User ID: mypacific Password: benefits.

## 12. LONG TERM DISABILITY

Please check the box indicating that you understand that participation is mandatory and a condition of employment.

## 13. SIGNATURE OF AGREEMENT & PAYROLL AUTHORIZATION

## 14. AUTHORIZATION OF ARBITRATION AGREEMENT AND UNDERSTANDING OF NON-PARTICIPATING PROVIDER INFORMATION / OTHER COVERAGE

The employee **MUST** sign and date where indicated.

Other Coverage- If you check Y indicating that other coverage exists, please complete the requested Other Coverage information. Attach additional sheet if necessary.

## 15. DECLINATION OF COVERAGE/CANCELLATION

Complete all requested information if declining or cancelling medical coverage for yourself and your dependents, sign and date.

## 16. ADULT CHILD ELIGIBILITY CERTIFICATION

In order to enroll or continue adult dependent child coverage under the Group Health Plan For Employees of University of the Pacific, the employee must certify that their adult child dependent age 19 up to age 26 is not eligible for health coverage under his or her own employer's plan or their spouse's plan (if married.) Additionally, Pacific reserves the right to require proof the adult dependent child is not eligible under his or her employer's plan. To certify, sign and date.

**RETURN YOUR ENROLLMENT/CHANGE FORM TO HUMAN RESOURCES.**

*Retain a copy for your records*

2012 SMART BENEFITS Enrollment/Change Form

Please read the Enrollment Form Instructions on the front side before completing this form.

1. EMPLOYEE PERSONAL INFORMATION

EMPLOYEE #, LAST NAME (Print), FIRST NAME (Print), M.I., SEX, MARRIAGE STATUS, HOME STREET ADDRESS, CITY, ZIP, DATE OF HIRE, HOME PHONE, WORK PHONE, BIRTH DATE, SOCIAL SECURITY NUMBER, EMPLOYMENT STATUS, NUMBER OF PAY PERIODS ANNUALLY

2. VOLUNTARY TERM LIFE INSURANCE

VOLUNTARY TERM LIFE AND AD&D INSURANCE, Employee Coverage, Spouse Coverage, Child(ren) Coverage, COST PER PAY PERIOD FOR \$1,000 OF VOLUNTARY TERM LIFE & AD&D INSURANCE table

3. HEALTH COVERAGE (includes Vision/Pre-Tax)

SELECT ONE MEDICAL PLAN & LEVEL OF COVERAGE: Anthem Blue Cross HMO Plan, Kaiser Permanente HMO Plan, Anthem Blue Cross POS Plan, Waive Coverage

4. SPOUSE INFORMATION

You MUST answer the following questions if you have elected to cover your Spouse/Domestic Partner under your Medical Plan. Is your spouse/domestic partner employed by UOP? Is your spouse/domestic partner eligible to participate in their employer's medical plan?

5. DENTAL COVERAGE (Pre-Tax)

SELECT ONE DENTAL PLAN & LEVEL OF COVERAGE: DeltaCare USA DHMO, Delta Dental PPO, Waive Coverage

6. EMPLOYEE & FAMILY INFORMATION

Please list yourself and all dependents (attach additional sheets if necessary)

Table with columns: LAST NAME (Print), FIRST NAME (Print), M.I., SOCIAL SECURITY NUMBER, DATE OF BIRTH, ADULT DEPENDENT CHILD, ENROLL IN (MEDICAL, DENTAL, VOLUNTARY LIFE COVERAGE), HAS OTHER MEDICAL, QUALIFIED AS IRS DEPENDENT, GENDER, DeltaCare Dentist Code, ANTHEM BLUE CROSS Medical Group Code, ANTHEM BLUE CROSS HMO or POS IPA Primary Care Physician Code, IS THIS YOUR CURRENT MD?

7. HEALTH CARE ACCOUNT FSA (Pre-Tax)

Health Care Flexible Spending Account Election: I elect to contribute \$\_\_\_\_\_ per pay period x \_\_\_\_\_ (# of annual pay periods) = \$\_\_\_\_\_ Plan Year Total

10. PARKING SPENDING ACCOUNT-Off University Premise (Pre-Tax)

Parking Flexible Spending Account Election: I elect to contribute \$\_\_\_\_\_ per pay period x \_\_\_\_\_ (# of annual pay periods) = \$\_\_\_\_\_ Plan Year Total

13. SIGNATURE OF EMPLOYEE ACCEPTANCE & PAYROLL AUTHORIZATION

This will confirm that I have received information on Pacific's health and welfare and retirement plans, as well as the Pacific Employee Handbook that includes, but is not limited to, information on paydays and pay reporting; sick leaves, vacation, holidays; workers' compensation; drug free workplace; non-discriminatory hiring; COBRA rights; and key policies and procedures. I acknowledge it is my responsibility to notify eligible family members of their COBRA rights to continue health coverage.

8. DEPENDENT CARE ACCOUNT FSA (Pre-Tax)

Dependent Care Flexible Spending Account Election: I elect to contribute \$\_\_\_\_\_ per pay period x \_\_\_\_\_ (# of annual pay periods) = \$\_\_\_\_\_ Plan Year Total

11. SUPPLEMENTAL BENEFITS - AFLAC & LONG TERM CARE

If interested access Pacific's Benefits Website for additional information. www.mypacific.myusi.com User ID: mypacific Password: benefits.

9. TRANSIT/VANPOOLING ACCOUNT (Pre-Tax)

Transit/Vanpooling Spending Account Election: I elect to contribute \$\_\_\_\_\_ per pay period x \_\_\_\_\_ (# of annual pay periods) = \$\_\_\_\_\_ Plan Year Total

12. LONG TERM DISABILITY

I understand that as a condition of employment it is mandatory that I participate.

EMPLOYEE SIGNATURE DATE

REMAIN A COPY OF THIS FORM FOR YOUR RECORD

**14. AUTHORIZATION OF ARBITRATION AGREEMENT AND UNDERSTANDING OF NON-PARTICIPATING PROVIDER INFORMATION / OTHER COVERAGE**

(Sign & date EITHER Anthem Blue Cross or Kaiser Permanente as appropriate)

**ANTHEM BLUE CROSS LEGAL LANGUAGE**

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

**NON-PARTICIPATING PROVIDER:**

I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

**REQUIREMENT FOR BINDING ARBITRATION**

The following provision does not apply to class actions:

**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 OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Health and 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 incompetently 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." 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 FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.**

EMPLOYEE SIGNATURE - Required for Anthem Blue Cross Plans

DATE

**OTHER MEDICAL COVERAGE:**

Policyholder: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Primary:  Yes  No

Carrier Name : \_\_\_\_\_

Group #: \_\_\_\_\_

**OR**

**KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

EMPLOYEE SIGNATURE - Required for Kaiser Permanente HMO Plan

DATE

**15. DECLINATION OF COVERAGE/ CANCELLATION - Medical Only**

The options of group medical coverage for myself and my eligible dependents (if any) for which I am eligible have been explained and made available to me by University of the Pacific. I have decided to decline/cancel my coverage and coverage for my eligible dependents (if any) as indicated below for (please check):

- Any/All medical plan options.
- I am covered as an eligible dependent in one of the university group plans
- I am covered under a non-university group plan
- Other; specify reason \_\_\_\_\_

I understand that the next opportunity to enroll in a medical plan will be during the next University open enrollment period, or if outside the open enrollment period, due to a qualifying status change.

EMPLOYEE SIGNATURE

DATE

**16. ADULT CHILD ELIGIBILITY CERTIFICATION**

I certify that my adult dependent child whom I have elected to enroll in one of the medical plans in the Group Health Plan For Employees of University of the Pacific\*, is not eligible to participate in his or her own employer's plan or the employer's plan of his or her spouse if eligible child is married. I understand it is my responsibility to notify Human Resources within 31 days of the date my adult dependent child becomes eligible under his or her employer's plan. I acknowledge and understand that failure to notify Human Resources within the 31 days of the event will result in termination of coverage retroactive to the last eligible date, recovery of all claim payments and possible forfeiture of premium paid.

EMPLOYEE SIGNATURE

DATE

\* Adult Child Eligibility Certification rules do not apply to Anthem Blue Cross Point of Service (POS) coverage.