

# OPEN ENROLLMENT FORM INSTRUCTIONS

## 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 you must also complete a Standard Medical History Statement Form which will be mailed to you.

You may cancel your coverage at anytime, however, you may not increase or decrease your coverage unless there is a *Qualifying Life Event*.

*\*Please make photo copies of the Medical History Statement Form or request additional forms from HR.*

## 3. HEALTH COVERAGE

Select appropriate boxes. If you elect medical coverage, please sign under the appropriate plan in Section 12 on the reverse side of the form. If you waive medical coverage, you must also complete the Waiver of Declination form. Premiums are paid on a pre-tax basis per pay period. If you are covering your spouse/domestic partner you must complete Sections 4 and 6. If you are covering dependents, complete Section 6.

**NOTE:** You may NOT change your Health and Dental elections during the Plan Year unless you have a *Qualifying Life Event*. Your CHANGE request must be received by Human Resources (HR) within 31 days of the event.

## 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.

## 5. DENTAL COVERAGE

See "HEALTH COVERAGE" above.

## 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 exist, please complete the Other Coverage information in Section 12

Check the **Totally Disabled** box **ONLY** if condition prohibits covered persons from working or performing daily activities.

### Anthem Blue Cross Participants

If you are a new enrollee to the Anthem Blue Cross HMO or POS plans, you and your dependents **MUST** select a Primary Care Physician (PCP) and Medical Group or Independent Practice Association (IPA) from the Anthem Blue Cross on-line Provider Finder at [www.anthem.com/ca](http://www.anthem.com/ca) or one will be selected for you. **Once you have made this selection, you will need to call Anthem Blue Cross Customer Service to document your selection no sooner than December 17, 2009.** Current participants should contact Anthem Blue Cross Customer Service (at any time) if you wish to change your PCP.

## 7. HEALTH CARE ACCOUNT (HCA)

## 8. DEPENDENT 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.

You may **NOT** increase, decrease or stop your account deposits during the plan year unless you have a *Qualifying Life Event*. Your CHANGE request must be received by HR within 31 days of the event.

UNUSED contributions are automatically forfeited at the end of the plan year—"Use It Or 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 \$230.00.

Parking Spending Account (off-site): Monthly maximum is \$230.00\*

*\*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 \$230.*

## 11. SIGNATURE OF AGREEMENT & PAYROLL AUTHORIZATION

## 12. 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.

## 13. DECLINATION OF COVERAGE/CANCELLATION

If declining/canceling coverage due to having other coverage, and that coverage is COBRA coverage, the COBRA coverage must be exhausted for the qualifying status change to apply. If other coverage was not COBRA, then the other coverage must terminate because of one of the following:

- (1) Employer contributions towards the coverage has been terminated, or
- (2) Loss of eligibility under other coverage such as:
  - Termination of employment or eligibility or reduction in work hours
  - Legal separation, divorce, termination of domestic partnership
  - Death of spouse or domestic partner

Loss of eligibility does not include loss of coverage due to the failure of individuals to pay.

Written verification of the loss of coverage is required. Acceptable documentation would be the COBRA letter indicating the exhaustion of the COBRA eligibility period, a death certificate, or official documents for the divorce, legal separation, or termination of domestic partnership.

If you decline/cancel university group medical coverage and do not have other coverage, and then have a new dependent as a result of marriage/domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 31 days after the marriage/domestic partnership, birth, adoption or placement for adoption.

**RETURN YOUR ENROLLMENT FORM TO HUMAN RESOURCES BY DECEMBER 2, 2009.**

# 2010 SMART BENEFITS Open Enrollment Form

University of the Pacific  
Open Enrollment coverage effective January 1, 2010

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.	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED
HOME STREET ADDRESS	CITY	ST	ZIP	DATE OF HIRE	NUMBER OF PAY PERIODS ANNUALLY
HOME PHONE	WORK PHONE	BIRTH DATE MO DAY YR	SOCIAL SECURITY NUMBER	EMPLOYMENT STATUS	<input type="checkbox"/> 18 (9 Months) <input type="checkbox"/> 20 (10 Months) <input type="checkbox"/> 22 (11 Months) <input type="checkbox"/> 24 (12 Months)
( ) - ( ) - / /	( ) - ( ) - / /			<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time (30+ hours a week) <input type="checkbox"/> Part Time (20-29 hours a week)	

## 2. VOLUNTARY TERM LIFE INSURANCE

**VOLUNTARY TERM LIFE AND AD&D INSURANCE**

**Employee Coverage:** (Check One)

NONE

OPTION 1: 1 Times Annual Base Salary

OPTION 2: 2 Times Annual Base Salary

OPTION 3: 3 Times Annual Base Salary

**Spouse Coverage\*:**  
Can elect \$10,000 to \$50,000 in increments of \$10,000.

Please indicate volume of coverage desired:  
\$ \_\_\_\_\_ or  NONE

**Child(ren) Coverage:** (Check One)  
Amounts reflect cost per pay period. Single rate for one or more children.

NONE  \$10,000 = \$0.44  
 \$5,000 = \$0.22  \$20,000 = \$0.88  
\* (Can not exceed 50% of employee combined Basic & Voluntary coverage).

Age	Employee/Spouse
Under 30	\$0.35
30 - 34	\$0.38
35 - 39	\$0.48
40 - 44	\$0.60
45 - 49	\$0.90
50 - 54	\$1.35
55 - 59	\$2.35
60 - 64	\$2.85
65 - 69	\$5.10
70 - 74	\$8.85
75 - 79	\$2.09

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

**SELECT ONE MEDICAL PLAN & LEVEL OF COVERAGE:**

Anthem Blue Cross HMO Plan  Employee Only

Kaiser Permanente HMO Plan  Employee Plus One

Anthem Blue Cross POS Plan  Employee Plus Family

Waive Coverage (Complete Section 13 - on reverse)

## 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?  Yes  No

Is your spouse/domestic partner eligible to participate in their employer's medical plan?  Yes  No

Is your spouse/domestic partner participating in their employer's medical plan?  Yes  No

What is his/her employer's company name and telephone number?  
\_\_\_\_\_ ( ) \_\_\_\_\_

## 5. DENTAL COVERAGE (Pre-Tax)

**SELECT ONE DENTAL PLAN & LEVEL OF COVERAGE:**

Delta Dental PPO  Employee Only

Waive Coverage  Employee Plus One

Employee Plus Family

## 6. EMPLOYEE & FAMILY INFORMATION

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

	LAST NAME (Print)	FIRST NAME (Print)	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	FULL-TIME STUDENT	ENROLL IN			HAS OTHER MEDICAL	QUALIFIED AS IRS DEPENDENT	TOTALLY DISABLED	GENDER	ANTHEM BLUE CROSS Medical Group Code	ANTHEM BLUE CROSS HMO or POS IPA Primary Care Physician Code	IS THIS YOUR CURRENT MD?
							MEDICAL COVERAGE	DENTAL COVERAGE	VOLUNTARY LIFE COVERAGE							
EMPLOYEE					/ /	Y N	Y N	Y N	Y N	Y N	Y N	M F	(3 digit)	(6 digit)	Y N	
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER					/ /								SEE INSTRUCTIONS BEFORE COMPLETING	SEE INSTRUCTIONS BEFORE COMPLETING		
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER					/ /											
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER					/ /											
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER					/ /											
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER					/ /											

## 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

## 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

## 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

## 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

## 11. SIGNATURE OF EMPLOYEE ACCEPTANCE & PAYROLL AUTHORIZATION

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan(s). Any misstatement or omissions may result in future claims being denied and/or the policy being rescinded. If applicable, I authorize my employer to deduct any required contributions from my earnings each pay period on a pre-tax basis unless I have provided written instructions to do otherwise. I understand that the coverage I have selected will not become effective on my eligibility date unless, or until, I am "actively at work."

EMPLOYEE SIGNATURE

RETAİN A COPY OF THIS FORM FOR YOUR RECORD

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

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

### ANTHEM BLUE CROSS

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: \_\_\_\_\_

Carrier Name : \_\_\_\_\_ Group #: \_\_\_\_\_

Primary:  Yes  No

**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 a group that is subject to ERISA, 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

## 13. 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 the 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