UNIVERSITY OF THE PACIFIC

2018 Benefit Enrollment/Change Form

❑ NEW ENROLLMENT ❑ OPEN ENROLLMENT ❑ EMPLOYEE HSA CHANGE ONLY ❑ TRANSIT AND/OR PARKING CHANGE ONLY

❑ QUALIFYING LIFE EVENT(please provide event details) ____________ DATE OF LIFE EVENT* ____________ EFFECTIVE DATE** ____________

**Enrollments/changes must be submitted to Human Resources within 31 days of the date of event*

***Effective date is the 1st of the month following date of event*

EMPLOYEE PERSONAL INFORMATION

EMPLOYEE# 98	LAST NAME	FIRST NAME	M.I.	❑ MALE ❑ FEMALE
JOB TITLE		DATE OF HIRE	CAMPUS Stockton	❑ SINGLE ❑ MARRIED ❑ DIVORCED
HOME ADDRESS	CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	DOB	SOCIAL SECURITY NUMBER	

DEPENDENT INFORMATION PLEASE LIST ALL DEPENDENTS (ATTACH ADDITIONAL SHEETS IF NECESSARY). **SELECT TO ENROLL AND INCLUDE IN BENEFITS**

SELECT ONE	LAST NAME (PRINT)	FIRST NAME (PRINT)	M. I.	DOB	SOCIAL SECURITY NUMBER	MEDICAL	DENTAL	VOLUNTARY LIFE	HAS OTHER MEDICAL
❑ SPOUSE ❑ DOMESTIC PARTNER ❑FEMALE ❑MALE									
❑ SON ❑ DAUGHTER ❑ OTHER									
	ADULT DEPENDENT CHILD AGE 19 UP TO 26 IS ELIGIBLE FOR OWN EMPLOYERS HEALTH PLAN ❑ YES ❑ NO					QUALIFIED AS IRS DEPENDENT ❑ YES ❑ NO			
❑ SON ❑ DAUGHTER ❑ OTHER									
	ADULT DEPENDENT CHILD AGE 19 UP TO 26 IS ELIGIBLE FOR OWN EMPLOYERS HEALTH PLAN ❑ YES ❑ NO					QUALIFIED AS IRS DEPENDENT ❑ YES ❑ NO			
❑ SON ❑ DAUGHTER ❑ OTHER									
	ADULT DEPENDENT CHILD AGE 19 UP TO 26 IS ELIGIBLE FOR OWN EMPLOYERS HEALTH PLAN ❑ YES ❑ NO					QUALIFIED AS IRS DEPENDENT ❑ YES ❑ NO			
❑ SON ❑ DAUGHTER ❑ OTHER									
	ADULT DEPENDENT CHILD AGE 19 UP TO 26 IS ELIGIBLE FOR OWN EMPLOYERS HEALTH PLAN ❑ YES ❑ NO					QUALIFIED AS IRS DEPENDENT ❑ YES ❑ NO			
❑ SON ❑ DAUGHTER ❑ OTHER									
	ADULT DEPENDENT CHILD AGE 19 UP TO 26 IS ELIGIBLE FOR OWN EMPLOYERS HEALTH PLAN ❑ YES ❑ NO					QUALIFIED AS IRS DEPENDENT ❑ YES ❑ NO			
❑ SON ❑ DAUGHTER ❑ OTHER									
	ADULT DEPENDENT CHILD AGE 19 UP TO 26 IS ELIGIBLE FOR OWN EMPLOYERS HEALTH PLAN ❑ YES ❑ NO					QUALIFIED AS IRS DEPENDENT ❑ YES ❑ NO			

ID#: 98 LAST NAME _____ FIRST NAME _____

BENEFIT PLAN

CODE	CHOOSE ONE MEDICAL PLAN COVERAGE	CHOOSE MEDICAL COVERAGE LEVEL
407	❑ Waive Medical Coverage	❑ Employee Only ❑ No Change
423	❑ Pacific Med- EPO	❑ Employee + 1
426	❑ Pacific Med- PPO	❑ Employee + Family
422/427/437	❑ Pacific Med- PPO-HD & Pacific Health Savings Account	
404/414	❑ Kaiser Permanente HMO Plan	
424/425/428/438	❑ Kaiser Permanente Deductible Plan w/HSA	

2018 ANNUAL EMPLOYEE HSA CONTRIBUTION LIMITS
SELF: $h̲нлл FAMILY: $4,400
CATCH UP CONTRIBUTIONS (age 55 or older): Ь$1,000

EMPLOYEE HEALTH SAVINGS ACCOUNT CONTRIBUTION

$_____per pay period x _____ # of pay periods

CODE	CHOOSE ONE DENTAL PLAN COVERAGE	CHOOSE DENTAL COVERAGE LEVEL
435	❑ Waive Dental Coverage	❑ Employee Only ❑ No Change
420	❑ Delta Dental PPO	❑ Employee + 1
421	❑ DeltaCare USA DHMO	❑ Employee + Family

CODE	ELECT FLEXIBLE SPENDING COVERAGE	COMPLETE THIS SECTION IF FLEXIBLE SPENDING ELECTED	
470	❑ Health Care Flexible Spending Account	$_____ per pay period x ____ # of pay periods	$2,600 annual maximum
475	❑ Dependent Care Spending Account	$_____ per pay period x ____ # of pay periods	$2,500 single or $5,000 family annual maximum
471	❑ Transit/Vanpooling (SF ONLY)	$_____ per pay period x ____ # of pay periods	$ 255 monthly maximum
472	❑ Parking Spending Account (SF ONLY)	$_____ per pay period x ____ # of pay periods	$ 255 monthly maximum

Monthly and Annual maximum limits on flexible spending accounts are subject to change per IRS guidelines

CODE	ELECT VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT	COMPLETE THIS SECTION IF VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT ELECTED
L50/L70	❑Liberty Mutual Employee Life/AD&D	_____x's salary up to 5x's ❑ No Change
L20/L35	❑Liberty Mutual Spouse or Domestic Partner Life/AD&D *If your spouse/domestic partner is a Pacific employee you may not elect coverage for them	$_____ (increments of $10,000; not to exceed $50,000) ❑ None ❑ No Change (Note: cannot exceed 50% of employee's combined Basic and voluntary coverage)
LCC	❑Liberty Mutual Child Life	❑ $0 ❑ $5,000 ❑ $10,000 ❑ $20,000 ❑ No Change
L60/L65	Unum Whole Life and Accident Policy	Contact Unum at 866.679.3054
	Long Term Care	Contact Deb Rauser at darauser@acsiapartners.com or 650-306-0240; www.debrarauser.itcfp.com

You MUST answer the following questions if you have elected to cover your Spouse/Domestic Partner under your Plan.

Is your spouse/domestic partner employed by Pacific? ❑ 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?

_____

Spouse/Domestic Partner Employer Name Phone Number

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This will confirm that I have received information on Pacific's health and welfare and retirement plans. I acknowledge it is my responsibility to notify eligible family members of their COBRA rights to continue health coverage. 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 _____ DATE _____

PACIFIC MEDICAL PLAN ARBITRATION AGREEMENT

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. **DEDUCTION AUTHORIZATION:** If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums. **NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. **HIV TESTING PROHIBITED:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance. **EFFECTIVE DATE:** The effective date of coverage is subject to Anthem Blue Cross approval.

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT UNIVERSITY OF THE PACIFIC AND PACIFIC MEDICAL PLANS 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 UNIVERSITY OF THE PACIFIC AND PACIFIC MEDICAL PLANS 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.**

EMPLOYEE SIGNATURE _____ DATE _____

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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.

SIGNATURE REQUIRED FOR KAISER PERMANENTE PLAN _____ DATE _____

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Adult Children are eligible to participate in Pacific's benefit plans

Children up to the age of 26 can join or remain on your medical, dental, and life insurance plan even if they are:

- Married,
- Not living with you,
- Attending school,
- Not financially dependent upon you, and
- Eligible to enroll in their employers plan.

WAIVER OF MEDICAL COVERAGE

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 - please 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 life event change.

_____ _____

EMPLOYEE SIGNATURE DATE

2018 Enrollment/Change Form Instructions

Mid-year changes listed below are NOT allowed except for Qualifying Life Events and/or OPEN ENROLLMENT:

- Add or remove yourself or your dependents from your Health and Dental Plans
- Increase or decrease coverage under any Life and Accidental Death & Dismemberment 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.

Adding Spouse or Domestic Partner - It is the responsibility of the employee to inform HR of any changes. A copy of the marriage certificate or certification of domestic partnership is required to add spouse/domestic partner to the plan.

DeltaCare USA Participants - You may elect to choose a 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.