



UNIVERSITY OF UTAH HEALTH CARE PLAN EMPLOYEE AND PARTNER ENROLLMENT FORM

Employee Information

Name: _____ Employee ID No.: _____

Address: _____ Social Security No.: _____

City: _____ St: _____ Zip: _____ Daytime Phone: _____

Enrollment Elections

I hereby apply on behalf of myself and listed eligible dependents for membership in the University of Utah's Health Care Plan as indicated below.

Full-Time Rates effective 07/01/08

Rates shown below are monthly and are deducted from the employee's paycheck.
If you participate in the **Wellness Program** you will receive a monthly discount of up to \$40.

Network Option	Plan Option	Employee + Partner	Employee + Partner + Employee's Child(ren)	Employee + Partner + Employee's and/or Partner's Child(ren)
University Health Care Plus	Basic	<input type="checkbox"/> \$ 345.02	<input type="checkbox"/> \$ 362.42	<input type="checkbox"/> \$ 625.62
	Comprehensive	<input type="checkbox"/> \$ 381.34	<input type="checkbox"/> \$ 411.20	<input type="checkbox"/> \$ 674.41
	Advantage	<input type="checkbox"/> \$ 401.32	<input type="checkbox"/> \$ 438.02	<input type="checkbox"/> \$ 701.22
ValueCare	Basic	<input type="checkbox"/> \$ 345.66	<input type="checkbox"/> \$ 375.38	<input type="checkbox"/> \$ 638.58
	Comprehensive	<input type="checkbox"/> \$ 390.98	<input type="checkbox"/> \$ 424.16	<input type="checkbox"/> \$ 687.37
	Advantage	<input type="checkbox"/> \$ 410.96	<input type="checkbox"/> \$ 450.98	<input type="checkbox"/> \$ 714.80
BlueCross BlueShield	Basic	<input type="checkbox"/> \$ 380.84	<input type="checkbox"/> \$ 410.56	<input type="checkbox"/> \$ 673.76
	Comprehensive	<input type="checkbox"/> \$ 417.16	<input type="checkbox"/> \$ 459.34	<input type="checkbox"/> \$ 722.55
	Advantage	<input type="checkbox"/> \$ 437.14	<input type="checkbox"/> \$ 486.16	<input type="checkbox"/> \$ 749.36

Please note: All rates include dental coverage

Waive Dental (Deduct amount shown from above rates)	<input type="checkbox"/> -\$ 44.24	<input type="checkbox"/> -\$ 58.24	<input type="checkbox"/> -\$ 79.20
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Enrollee Information

	Name	Add or Drop	Gender	Relationship	Birthdate
Self		<input type="checkbox"/>	<input type="checkbox"/> Male	Self	
			<input type="checkbox"/> Female		
Partner		<input type="checkbox"/>	<input type="checkbox"/> Male	Partner	
			<input type="checkbox"/> Female		
Dependent Children Under Age 26 (Includes: Adopted Children, Step Children, and Legal Guardianship Children. Please include surname if different)		<input type="checkbox"/>	<input type="checkbox"/> Male	<input type="checkbox"/> My Child	
			<input type="checkbox"/> Female	<input type="checkbox"/> Partner's Child	
		<input type="checkbox"/>	<input type="checkbox"/> Male	<input type="checkbox"/> My Child	
			<input type="checkbox"/> Female	<input type="checkbox"/> Partner's Child	
		<input type="checkbox"/>	<input type="checkbox"/> Male	<input type="checkbox"/> My Child	
			<input type="checkbox"/> Female	<input type="checkbox"/> Partner's Child	
		<input type="checkbox"/>	<input type="checkbox"/> Male	<input type="checkbox"/> My Child	
			<input type="checkbox"/> Female	<input type="checkbox"/> Partner's Child	
		<input type="checkbox"/>	<input type="checkbox"/> Male	<input type="checkbox"/> My Child	
			<input type="checkbox"/> Female	<input type="checkbox"/> Partner's Child	

Benefits Dept. Use Only	Entry Date:	Entered By:	QC By:	QC Date:
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Certification of Eligibility

I hereby certify that my Partner named above and I meet the following eligibility requirements:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	We are both over the age of eighteen (18).
<input type="checkbox"/>	<input type="checkbox"/>	We reside together in a permanent residence and have done so for at least six months and will remain members of the same household for the period of coverage.
<input type="checkbox"/>	<input type="checkbox"/>	We have a serious and committed relationship which we intend to continue indefinitely.
<input type="checkbox"/>	<input type="checkbox"/>	We are emotionally committed to one another and jointly responsible for the common welfare and financial obligations of our household or one of us is chiefly dependent upon the other for financial assistance.
<input type="checkbox"/>	<input type="checkbox"/>	We are not related in any way that would prohibit legal marriage. <i>(If true, mark "Yes")</i>
<input type="checkbox"/>	<input type="checkbox"/>	Neither of us is legally married to anyone else or the partner of anyone else. <i>(If true, mark "Yes")</i>
If I am enrolling my Partner's children, I certify the children:		
<input type="checkbox"/>	<input type="checkbox"/>	Receive more than 50% of their support from me and/or my Partner.
<input type="checkbox"/>	<input type="checkbox"/>	Live in my household as their principal place of residence (unless they live at school or elsewhere as the result of a divorce or legal separation).
<input type="checkbox"/>	<input type="checkbox"/>	Are not married. <i>(If true, mark "Yes")</i>
<input type="checkbox"/>	<input type="checkbox"/>	Are not employed on a full-time basis, except for school vacations. <i>(If true, mark "Yes")</i>
<input type="checkbox"/>	<input type="checkbox"/>	Are under the age of 26 (I understand they may continue coverage at age 26 if they are unmarried, full-time students, and dependent on me).

Employee Certification

I hereby certify the following:

- I agree to the terms and conditions in the Master Health Care Plan.
- My Partner and I still meet the eligibility requirements:
 - We reside together in a permanent residence and have done so for at least six months and will remain members of the same household for the period of coverage.
 - We have a serious and committed relationship which we intend to continue indefinitely.
 - We are emotionally committed to one another and jointly responsible for the common welfare and financial obligations of our household or one of us is chiefly dependent upon the other for financial assistance.
 - Neither of us is legally married to anyone else or the partner of anyone else.
- I understand that the information provided in all parts of this form is true and correct and that if any information is not true and correct, I may be subject to disciplinary action up to and including termination of employment.
- I agree to notify the University of Utah Benefits Department immediately if our Partner relationship ends.
- I understand that the persons named above will cease to be eligible under the Plan if a change in status occurs wherein they fail to meet any of the above conditions. I agree to notify the University Benefits Department of any changes in status that result in ineligibility of any of the persons named above.
- I understand that if I wish to add a dependent to my coverage after a life event/status change (e.g., marriage, birth or adoption, etc.) I must request the change within three months of the date of the event or I will forfeit any right to make the change until the next annual open enrollment.
- In the event any of the persons named above is found to be ineligible under the Plan, I agree to reimburse the Plan for any amounts paid during the time that such person was ineligible.
- I understand that the University of Utah has the right to discontinue coverage at any time and that extending a COBRA-like coverage to my Partner is not legally required and also may be discontinued at any time.
- I understand that a court or other adjudicative agency may require the University of Utah to make the records of my partnership public under the Freedom of Information Act or other applicable law.
- I understand the health care coverage does not cover treatment of pre-existing conditions provided during the first six months following enrollment; unless, the pre-existing condition waiting period is reduced by a period(s) of prior creditable coverage as defined by HIPAA. I am responsible for submitting a certificate(s) or other evidence of prior creditable coverage.
- I hereby agree to pay for the coverage requested through payroll deduction of after-tax dollars.
- I will provide evidence that the eligibility requirements have been met and/or verification of my joint responsibility and shared financial obligations with my Partner upon request by the University of Utah Benefits Department.

Employee

Date

Statement of Understanding and Agreements

HEALTH AND DENTAL COVERAGE

As an employee in a benefit-eligible position, I may enroll in the University of Utah Employee Health Care Plan medical and dental options within 3 months of the date I am hired into a benefit-eligible position. I understand that participation in one of the medical options is a prerequisite for participation in the dental option and that all dependents enrolled in health coverage will automatically be enrolled in dental coverage, if dental coverage is elected. I understand I may make changes to my coverage if I experience a status change event (as defined by the Internal Revenue Service; e.g., marriage, divorce, birth, loss of other coverage, etc.) if such change is made within three (3) months of the date of the status change event. If the written request is not submitted to the Benefits Department within 3 months, I will forfeit any right to make a change until the next annual open enrollment, if any.

I understand that **eligible dependents** are the person to whom I am legally married and my (or my spouse's) unmarried children by birth, placement for legal adoption or foster care, or legal court-appointed guardianship, who are under age 26 and dependent on me for more than 50% of their support. I agree to notify the Benefits Department if one of my enrolled dependents is no longer an eligible dependent. I understand that I must provide notification within 60 days in order for the dependent to be eligible for COBRA Continuation Coverage.

PREEXISTING CONDITION WAITING PERIOD

To the extent allowed under federal law, I understand the health care plan does not cover treatment of preexisting conditions for newly enrolled participants during the first 6 months following enrollment or, for late enrollees, during the first 18 months following enrollment; unless this preexisting condition waiting period is reduced by a period(s) of prior creditable coverage as defined by HIPAA. I am responsible for submitting a certificate(s) or other evidence of prior creditable coverage. A Preexisting Condition is defined as a physical or mental condition, except for pregnancy, whether diagnosed or misdiagnosed, which within the six-month period before your Enrollment Date (defined in the Plan):

- You incurred expense, received medical treatment, services or advice, underwent diagnostic procedures, took prescribed drugs or medicine, or consulted a physician or other licensed medical professional; or
- Was discovered or suspected as a result of any medical examination, including a routine medical examination.

The Plan will not impose a waiting period for a preexisting condition for a newborn child, an adopted child, or a child placed with me for adoption if I complete the paperwork to add the child within 3 months of the birth, adoption, or placement, respectively.

AGREEMENT

I hereby make application on behalf of myself and listed eligible family dependents for membership in the University of Utah Employee Health Care Plan as indicated hereon and agree to the terms and conditions in the Master Policy. I understand that if I am eligible and this enrollment form is completed and provided to the University Benefits Department timely, my benefits will begin on my effective date as determined by the enrollment rules of the Plan.

To the minimum extent necessary to implement coverage, and in accordance with rules set forth in the HIPAA Privacy Regulations, I authorize Regence Blue Cross/Blue Shield of Utah, UUHP, and Caremark to request any medical, health, employment, and/or insurance information necessary to complete my enrollment. I authorize pretax payroll deduction of contributions as required through the provisions of IRC Section 125 Flexible Benefits. I agree to abide by the Plan's enrollment provisions. I authorize my employer to act as my agent in all matters of administration of the group program, and acknowledge that my employer is in no way acting as agent for those companies administering the Plan. To the extent authorized under applicable law, I accept Binding Arbitration as the method of resolving any disputes arising between me or my covered family member and the Plan, or a participating physician, concerning the applicability of benefits payable under the Plan. I understand that the University intends to continue the Plan(s) indefinitely; however, it reserves the right to amend, suspend or discontinue the Plan(s) at any time.

I certify that all information on this form is true and correct and acknowledge that my coverage is subject to cancellation if any completed information is found to be false or incorrect and I will be responsible for reimbursement to the Plan for any claims paid in error. I understand that knowingly providing a statement that contains any false, incomplete or misleading information may result in adverse employment action, up to and including termination of employment.

For detailed plan information, please refer to the Plan's Summary Plan Description. Summary Plan Descriptions are available on the internet at www.hr.utah.edu/ben or in the Benefits Department located at 420 Wakara Way, Ste. #105, Salt Lake City, UT 84108. Phone: 581-7447, Fax: 585-7375, e-mail: benefits@hr.utah.edu