UNIVERSITY OF UTAH HEALTH CARE PLAN
EMPLOYEE AND PARTNER ENROLLMENT FORM

Employee Information

Name: _____ Employee ID No.: _____

Address: _____ Email: _____

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 Employee Health Care Plan as indicated below.

Full-Time Rates effective 07/01/2010

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/Multiplan	Comprehensive	o $394.56	o $438.14	o $680.95
	Advantage	o $414.55	o $464.96	o $707.77
BlueCross Blue Shield/ValueCare	Comprehensive	o $404.20	o $451.10	o $693.91
	Advantage	o $424.19	o $477.92	o $720.73
High Deductible Health Plan (HDHP)	Call For Rates			

Please note: All rates include dental coverage

Waive Dental (Deduct amount shown from above rates)	o -$53.90	o -$73.46	o -$79.20

Enrollee Information

	Name	Add or Drop	Gender	Relationship	Birthdate
Employee		☐	o Male o Female	Self	
Partner		☐	o Male o Female	Partner	
Dependent Children Under Age 26 (Includes: Adopted Children, Step Children, and Legal Guardianship Children. Please include surname if different)		☐	o Male o Female	o My Child o Partner's Child	
		☐	o Male o Female	o My Child o Partner's Child	
		☐	o Male o Female	o My Child o Partner's Child	
		☐	o Male o Female	o My Child o Partner's Child	
		☐	o Male o Female	o My Child o Partner's Child	
		☐	o Male o Female	o My Child o Partner's Child	

Benefits Dept. Use Only	Entry Date:	Entered By:	QC By:	QC Date:

UNIVERSITY OF UTAH – BENEFITS DEPARTMENT
420 Wakara Way, Suite 105, Salt Lake City, UT 84108
Phone: (801) 581-7447 / Fax: (801) 585-7375

Certification of Eligibility

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

Yes	No	
o	o	We are both over the age of eighteen (18).
o	o	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.
o	o	We have a serious and committed relationship which we intend to continue indefinitely.
o	o	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.
o	o	We are not related in any way that would prohibit legal marriage. *(If true, mark "Yes")*
o	o	Neither of us is legally married to anyone else or the partner of anyone else. *(If true, mark "Yes")*
If I am enrolling my Partner's children, I certify the children:		
o	o	Receive more than 50% of their support from me and/or my Partner.
o	o	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).
o	o	Are not married. *(If true, mark "Yes")*
o	o	Are not employed on a full-time basis, except for school vacations. *(If true, mark "Yes")*
o	o	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.
- 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

- I hereby make application on behalf of myself and listed eligible family dependents for enrollment in the University of Utah Employee Health Care Plan as indicated hereon.
- I understand that participation in the University Health Care Plan is a prerequisite for enrollment in dental coverage.
- I understand that I may not change or cancel these elections during the plan year, unless I experience a status change event that would be consistent with my requested change and otherwise meets IRS criteria governing valid election changes. All plan election changes must be submitted within 3 months of the status change event date. Otherwise, I will forfeit any right to make this change until the next Annual Open Enrollment.
- To the extent allowed under federal law, I understand the Health Care Plan does not cover treatment of pre-existing conditions for new members during the first 6 months following timely enrollment or during the first 18 months following enrollment for late enrollees unless the pre-existing condition waiting period is reduced by prior creditable coverage as defined by HIPAA. I am responsible for submitting a certificate(s) or other evidence of prior creditable coverage.
- To the minimum extent necessary to implement coverage, and in accordance with rules set forth in the HIPAA Privacy Regulations, I authorize Regence BlueCross BlueShield of Utah, University Health Care Plus, Blonquist Hale Consulting, UNI BHN, CVS Caremark, and ASI Flex to request and use any medical, health, employment, and/or insurance information necessary to complete my enrollment, process my claims, provide coverage benefits, and administer coverage benefits.
- I authorize 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 claims.
- I certify that all information on this form is true and correct and I acknowledge that the University will take corrective action against Participants who (a) enroll an individual in the Health Care Plan that they know or should know is ineligible and/or (b) file claims (either directly or indirectly through a health care provider) for an individual that they know or should know is ineligible for coverage under the Plan. Corrective action includes termination of employment, legal action for reimbursement of all claims, and cancellation of coverage without the right to elect COBRA continuation coverage.
- I understand that the University intends to continue the Plan indefinitely; however, it reserves the right to amend, suspend or discontinue it at any time.

Social Security Numbers are Now Required for All Dependents

Beginning January 1, 2009, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 requires all health plans in the United States to report group and member information to the Centers for Medicare and Medicaid Services (CMS). The new law will help CMS accurately coordinate Medicare and group benefits for people who have both coverages. Since individuals under age 65 who have end stage renal disease or other disabilities are eligible for Medicare, we need to provide information, including social security numbers, for all enrolled members.

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: (801) 581-7447, Fax: (801) 585-7375, e-mail: benefits@hr.utah.edu