BENEFITS ENROLLMENT CHANGE FORM

BASIC LIFE, VOLUNTARY LIFE AND LONG TERM CARE BENEFIT CHANGES MAY BE SUBMITTED AT ANY TIME. MEDICAL, DENTAL AND CANCER PLAN BENEFIT CHANGES MUST BE SUBMITTED TO HUMAN RESOURCES WITHIN 31 DAYS FROM THE CHANGE IN FAMILY STATUS. OTHERWISE YOU MUST WAIT UNTIL OPEN ENROLLMENT.

NOTE: SUPPORTING DOCUMENTATION FOR ANY STATUS CHANGE IS REQUIRED WITH EACH CHANGE FORM SUBMITTED.

Complete & return with change form.

I wish to make a change in my benefit election under the: (please check all that apply)

Benefit changes for these plans must be made 31 days from the change in family status and/or during Open enrollment

_____ Blue Cross Benefit Plan
_____ Kaiser Permanente Benefit Plan
_____ Delta Dental Benefit Plan
_____ Cancer Plan

Benefit changes for the following plans may be done any time

_____ Basic Life
_____ Voluntary Life
_____ Long Term Care (LTC)

I hereby verify that this change is to be made on account of the change in family status indicated below which occurred (date) ________________.

<table>
<thead>
<tr>
<th>Marriage/registered domestic partner</th>
<th>Divorce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth or adoption of child</td>
<td>Overage dependent</td>
</tr>
<tr>
<td>Change of spouse’s/registered domestic partner’s employment status</td>
<td>Death</td>
</tr>
<tr>
<td>Change of employee’s employment status</td>
<td>Open Enrollment</td>
</tr>
</tbody>
</table>

NAME & ADDRESS CHANGES CAN BE MADE AT ANY TIME.

_____ Address Change Only
_____ Name Change Only

Name ____________________________________________
ID Number _______________________________________
Extension ________________________

*The effective date is dependent upon the type of family status change.

Contact the HR Service desk with questions at (408)554-4392

FOR HR OFFICE USE ONLY

Effective Date of Coverage with Carrier_______________
PeopleSoft Coverage Begin Date_____________________
PeopleSoft Deduction Begin Date____________________ Adjustment Needed □ Yes □ No
**SANTA CLARA UNIVERSITY**
**BENEFITS ENROLLMENT FORM**

- **☐ New Hire**
- **☐ Open Enrollment**
- **☐ Add/Delete Dependent**
- **☐ Change Of Address**
- **☐ Name Change**
- **☐ Change Of Beneficiary**

**Effective Date:** ____________________

*Employees eligible for health and welfare benefits must complete this form to enroll in these plans. Coverage begins on the first date of the month coinciding with or following the date of hire. Open Enrollment changes are effective January 1. The elections on this form can only be changed during the Open Enrollment period or in the event of a qualified change of family status.*

**EMPLOYEE INFORMATION**

- **Employee Name:** __________________________________________  **Employee ID #:** ____________________  **Date of Hire:** ____________________
  
  Last                                           First

- **Street Address:** __________________________________________  **Home Phone #:** ____________________

- **City:** ____________________  **State:** ____________________  **Zip:** ____________________

**COVERAGE SELECTION: ELECT HEALTH CARE PLAN**

<table>
<thead>
<tr>
<th>DENTAL:</th>
<th>MEDICAL:</th>
<th>HEALTH SAVINGS ACCOUNT:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>☐ DELTA DENTAL</strong></td>
<td></td>
<td>(Option only for those enrolled on the Blue Cross High Deductible H.S.A. compatible PPO Plan)</td>
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<tr>
<td></td>
<td><strong>☐ KAISER HMO</strong></td>
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<tr>
<td></td>
<td><strong>☐ BLUE CROSS HMO</strong></td>
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<td><strong>☐ BLUE CROSS Traditional PPO</strong></td>
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<td><strong>☐ BLUE CROSS HIA PPO</strong></td>
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<td><strong>☐ BLUE CROSS PPO w/ HSA → See Health Savings Account</strong></td>
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<td><strong>☐ WAIVER DENTAL/ SEE PAGE 2</strong></td>
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<td><strong>☐ WAIVER MEDICAL/ SEE PAGE 2</strong></td>
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<table>
<thead>
<tr>
<th>MEDICAL COVERAGE FOR:</th>
<th>*MEDICAL COVERAGE FOR:</th>
<th>*Note:</th>
<th>*Note:</th>
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<tbody>
<tr>
<td><strong>☐ Employee Only</strong></td>
<td><strong>☐ Employee Only</strong></td>
<td>Medical plan participation automatically includes vision benefits.</td>
<td>Medical plan participation automatically includes vision benefits.</td>
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<tr>
<td><strong>☐ Employee &amp; One Dependent</strong></td>
<td><strong>☐ Employee &amp; One Dependent</strong></td>
<td><em>All eligible employees and dependents are covered automatically in Employee Assistance Program (EAP).</em></td>
<td><em>All eligible employees and dependents are covered automatically in Employee Assistance Program (EAP).</em></td>
</tr>
<tr>
<td><strong>☐ Employee &amp; Two or More Dependents</strong></td>
<td><strong>☐ Employee &amp; Two or More Dependents</strong></td>
<td><em>All eligible employees are covered automatically in Basic Life/AD&amp;D, Short Term and Long Term Disability plans.</em></td>
<td><em>All eligible employees are covered automatically in Basic Life/AD&amp;D, Short Term and Long Term Disability plans.</em></td>
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*Please complete beneficiary information on second page of this form.*

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**HEALTH SAVINGS ACCOUNT:**

- 2010 Maximum Contribution Allowed:
  - $3050 - Individual Coverage,
  - $6150 - Family Coverage

$ __________ per year

*Please note that if you are enrolled in the H.S.A. plan, you can only enroll in the F.S.A. plan for “limited purpose” expenses, i.e.- dental and vision expenses only.*
EMPLOYEE AND DEPENDENT INFORMATION: Blue Cross HMO applicants must select a Primary Care Physician (PCP). Over age dependents will require verification of student status.

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Soc. Sec. #</th>
<th>PCP Name &amp; Number</th>
<th>Patient(Y/N)</th>
<th>Disabled(Y/N)</th>
<th>IRS Dep(Y/N)</th>
<th>Qualified</th>
<th>Add/ Delete</th>
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<td>Employee</td>
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FLEXIBLE BENEFITS PLAN

- Health Care Reimbursement $________ per year ($5,000 annual max.)
- Dependent Care Reimbursement $________ per year ($5,000 annual max.)

A supplemental form must be completed January 1st of each year.

LIFE AND AD&D BENEFICIARY DESIGNATIONS

<table>
<thead>
<tr>
<th>Basic Life/AD&amp;D Beneficiary Name(s)</th>
<th>Percentage</th>
<th>Relationship</th>
<th>Contingent</th>
<th>Address</th>
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DECLINATION OF COVERAGE

I waive my rights to the following benefits as provided by Santa Clara University effective the first day of ____________, 20__:

- No Medical Coverage for _____ Employee _____ Dependent(s) _____ Employee & Dependent(s)
- No Dental Coverage for _____ Employee _____ Dependent(s) _____ Employee & Dependent(s)

I am currently enrolled in the medical and/or dental benefit programs provided by
_____ spouse’s or registered domestic partner’s employer _____ my other employer _____ Medicare.

REFUSAL OF PERSONAL COVERAGE: I acknowledge that the coverage available to me has been explained to me by SCU and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependents, if any. I now decline to enroll myself, my spouse or registered domestic partner and/or my dependent(s) in SCU’s Blue Cross Health plan or Kaiser Health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

DECLINATION OF COVERAGE: If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer health benefit plan, I acknowledge that, if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in SCU’s health benefit plan within 31 days. Otherwise, I understand I may not enroll myself and/or my dependents in SCU’s health plans until SCU’s next open enrollment period.
BLUE CROSS OF CALIFORNIA ARBITRATION AGREEMENT

ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions:

I understand that any and all disputes between myself (and/or any enrolled family member) and Blue Cross of California/BC Life & Health, including claim for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the members and Blue Cross/BC Life & Health are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross/BC Life & Health and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to you Evidence of Coverage/Certificate.

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration after the ERISA claim appeal process is completed.

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.

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs 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, 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 my 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.

NEW DEPENDENT: If I acquire a new dependent as the result of marriage, registering as a Domestic Partner with the State of California, birth, adoption or placement for adoption, I acknowledge that I, and any dependents I may have, may request enrollment in SCU’s health plan by applying for that coverage within 31 days of the marriage, registering as a Domestic Partner with the State of California birth, adoption, or placement for adoption.

I understand that the benefit elections shown on this form will remain in effect unless there is a qualified family status change or employment terminates or I elect to change during a subsequent Open Enrollment period. I understand Flexible Spending Accounts must be elected annually. If a family status change takes place, I have up to 31 days from the date of change, to notify the Department of Human Resources in order to change any of the above elections. I authorize Santa Clara University to reduce my salary on a pre-tax basis for coverage (except for voluntary life and long term care) I have elected. I hereby certify that the designation of beneficiary(ies) was executed on this date and supersedes any earlier designation, and can be revoked in writing at any time. If no designated beneficiary survives me, settlement will be made as provided for in the policies issued by the insurance company(ies).

I certify that all enrolled family members and Registered Domestic Partners are eligible for coverage based on Santa Clara University's definitions and guidelines as set forth in the Plan Documents and that all information provided is true to the best of my knowledge, under penalty of perjury.

I understand that making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility within 31 days, or failing to provide documentation when requested may lead to a termination of the family members and to legal action. In addition, employees will be subject to disciplinary action (i.e. loss of health benefits) and will be responsible for any employer contributions to and benefits paid by the plans.

I, the applicant, have read and understand the information on this application in its entirety. I further attest that the information I have provided is true and accurate to the best of my knowledge.

SIGNATURE:    DATE: