University Corporation at Monterey Bay Benefits Enrollment Information

Welcome to The University Corporation. We are excited that you have accepted our job offer to join this great organization. Your benefits will be effective the first of the month following your hire date. Prior to the end of the month, please submit your enrollment paperwork to auoswald@csumb.edu or complete your enrollment directly in ADP.

Required

- Medical, Dental, Vision elections
- Premium reduction election form
- TIAA Automatic 6% enrollment form
- Retirement Account Enrollment Form (for employer 10% after 6 months)
- Voluntary Self-Identification for of Disability

Optional

- Payroll deduction form - if you would like parking and/ or gym/ pool please hold onto the form as we are not currently able to offer these deductions during Covid 19
- Salary Reduction Agreement - if you would not like the automatic 6% (you can select a higher or lower enrollment on the form)
- FSA - BCC (on Medical enrollment form)
- Voluntary life insurance
- Defensive Driving Program Enrollment – submit to nayala@csumb.edu

UNIVERSITY CORPORATION
CSU MONTEREY BAY
Research, Housing and Commercial Services

The University Corporation at Monterey Health Benefit Program

January 1 - December 31, 2024

Health Plan	Eligible Dependents	2024 Employee Monthly Deduction	2024 Employee Semi-Monthly Deduction	Employer Monthly Contribution
Blue Cross HMO*	Employee Only	$71.69	$35.85	$823.25
Plan A	Employee + 1 Dependent	$214.33	$107.17	$1,571.61
	Employee + 2 or more	$353.89	$176.95	$2,174.05
Kasier Permanente HMO*	Employee Only	$65.77	$32.89	$755.17
$20 Copay Plan	Employee + 1 Dependent	$196.69	$98.35	$1,442.25
	Employee + 2 or more	$324.77	$162.39	$1,995.17
Blue Cross - High Option	Employee Only	$95.69	$47.85	$1,099.25
PPO Plan 9060	Employee + 1 Dependent	$286.81	$143.41	$2,103.13
	Employee + 2 or more	$473.31	$236.66	$2,907.63
Blue Cross - Low Option	Employee Only	$67.09	$33.55	$1,048.85
PPO Plan 8060	Employee + 1 Dependent	$201.13	$100.57	$2,032.81
	Employee + 2 or more	$379.09	$189.55	$2,779.85
Vision - VSP	Employee Only	$0.00	$0.00	$7.00
(100% employer paid)	Employee + 1 Dependent	$0.00	$0.00	$9.70
	Employee + 2 or more	$0.00	$0.00	$16.60
Dental - Delta Dental	Employee Only	$0.00	$0.00	$46.40
(100% employer paid)	Employee + 1 Dependent	$0.00	$0.00	$92.80
	Employee + 2 or more	$0.00	$0.00	$143.40
100% Employer Paid Plans	**Eligible Dependents**	**2024 Employee Monthly Deduction**	**2024 Employee Semi-Monthly Deduction**	**Employer Monthly Contribution**
Life Insurance ($50,000)	Employee Only	$0.00	$0.00	based on salary
(AD&D) Accident Insurance ($50,000)	Employee Only	$0.00	$0.00	$0.50
Long Term Disability (up to 60% of earnings)	Employee Only	$0.00	$0.00	based on salary
Retirement (10% of gross, after 6 months)	Employee Only	$0.00	$0.00	based on salary
Workers Compensation	Employee Only	$0.00	$0.00	based on role
Other State and Federal Contributions		**2024 Employee Monthly Deduction**	**2024 Employee Semi-Monthly Deduction**	**Employer Monthly Contribution**
Medicare + Social Security (7.65%)	-	7.65%	7.65%	7.65%
Federal Income Tax	-	based on salary	based on salary	based on salary
State Income Tax	-	based on salary	based on salary	0.00%
Unemployment Insurance	-	$0.00	0.00%	1.07%
SDI, PFL		0.90%	0.90%	0.00%

CSURMA - AORMA
Benefit Election Form

Group Name: _____

Effective Date: _____

MEMBER ENROLLMENT OR CHANGE - COMPLETE IN FULL

Name (Last, First, MI)	Social Security #	Birth Date (mm/dd/yy):	☐ Male ☐ Female

Home Street Address (NO P.O. Box)	City	State	Zip	Home Phone:	Work Phone:
Mailing Address: (P.O. Box may be used)	City	State	Zip	E-mail Address:	

☐ Same as Home Address

Occupation/Title:	Date of Hire:	Employee Status: ☐ Full Time ☐ Early Retire ☐ Part Time ☐ Medicare Retiree

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Legally Separated ☐ Divorced

TYPE OF ACTION

☐ New Hire Enrollment (list all dependents to be covered)
☐ Annual Open Enrollment
☐ Add or Drop Dependent due to Qualifying Event: QE Event: _____/_____/_____
☐ Termination: last Date Employee Actively Worked: _____/_____/_____
☐ Other: _____
☐ Name/Address Change

MEMBER ELECTION APPLICABLE PLANS ONLY

Anthem PPO 90%
☐ EE Only
☐ EE + 1
☐ EE + Family

Anthem PPO 80%
☐ EE Only
☐ EE + 1
☐ EE + Family

Anthem Medicare COB PPO *
☐ Retiree Only
☐ Retiree + 1
☐ Retiree + Family

**** EGWP Express Scripts Medicare Prescription Plan Benefit Election form must also be completed to enroll in this plan.***

Anthem HMO Select $15
☐ EE Only
☐ EE + 1
☐ EE + Family
Employee PCP Code: _____
Provider Name: _____
Existing Patient: Yes☐ / No☐

Anthem HMO $20
☐ EE Only
☐ EE + 1
☐ EE + Family
Employee PCP Code: _____
Provider Name: _____
Existing Patient: Yes☐ / No☐

Anthem Medicare COB HMO
☐ Retiree Only
☐ Retiree + 1
☐ Retiree + Family

Anthem HDHP
☐ EE Only
☐ EE + 1
☐ EE + Family

Kaiser HMO $15
☐ EE Only
☐ EE + 1
☐ EE + Family
Employee PCP Code: _____
Provider Name: _____
Existing Patient: Yes☐ / No☐

Kaiser HMO $20
☐ EE Only
☐ EE + 1
☐ EE + Family
Employee PCP Code: _____
Provider Name: _____
Existing Patient: Yes☐ / No☐

Kaiser KPSA *
☐ Retiree Only
☐ Retiree + 1
☐ Retiree + Family

**** KPSA election form must also be completed to enroll in this plan.***

Delta Dental PPO _____ (Plan Name)
☐ EE Only
☐ EE + 1
☐ EE + Family

Delta Dental DHMO (if available)
☐ EE Only PCP Code:_____
☐ EE + 1 Provider:_____
☐ EE + Family Existing Patient:Yes☐/No☐

VSP Vision_____(Plan Name)
☐ EE Only
☐ EE + 1
☐ EE + Family

DEPENDENT COVERAGE

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #	Birth Date:	☐ Male ☐ Female
Home Street Address (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child
HMO Provider Name (HMO plans only):		Existing Patient: Yes ☐ / No ☐	PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #	Birth Date:	☐ Male ☐ Female
Home Street Address (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
HMO Provider Name (HMO plans only):		Existing Patient: Yes ☐ / No ☐	PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #	Birth Date:	☐ Male ☐ Female
Home Street Address (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
HMO Provider Name (HMO plans only):		Existing Patient: Yes ☐ / No ☐	PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #	Birth Date:	☐ Male ☐ Female
Home Street Address (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
HMO Provider Name (HMO plans only):		Existing Patient: Yes ☐ / No ☐	PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #	Birth Date:	☐ Male ☐ Female
Home Street Address (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
HMO Provider Name (HMO plans only):		Existing Patient: Yes ☐ / No ☐	PCP Code:	

ANTHEM & KAISER ARBITRATION PLEASE READ CAREFULLY - SIGNATURE REQUIRED

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 approval.

I certify each Social Security number listed on the application is correct.

ANTHEM - REQUIREMENT FOR BINDING ARBITRATION (not applicable to life and Disability coverage)

ALL DISPUTES BETWEEN YOU AND ANTEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURNACE COMPANY (ANTHEM), 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 OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, 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, COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING NOT LIMITED TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety code Section 13631. 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 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 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.*** **YOU AND ANTHEM AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT RE SUBJECT TO ARBITRATION UNDER STATE OF FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/O PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU.**

Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "handwritten or electronic" signature below, our acknowledge that such signature is valid and binding.

Signature (Required)

Applicant	Date (MM/DD/YY)
X	

KAISER - REQUIREMENT FOR BINDING ARBITRATION (not applicable to life and Disability coverage)

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), nay 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 be 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)

Applicant	Date (MM/DD/YY)
X	

DECLINATION OF COVERAGE (SIGNATURE REQUIRED - COMPLETE ONLY IF DECLINING MEDICAL COVERAGE)

I understand that I am eligible for medical coverage through my employer. I waive the right to enorll in the medical plan as offered by my employer for the following persons (please check all that apply below):

☐ Self ☐ Spouse ☐ Chid(ren)

Reason for Waiver:

☐ I have my own other group coverage
☐ We are covered through my spouse's employer
☐ My spouse and dependents have other group coverage

Retirees: *Once a plan is waived, you will no longer be eligible to enroll.*

I understand and agree by signing this document that I am declining coverage. I understand by declining coverage, I will not be eligible for coverage until my employer's next Open Enrollment period unless I qualify for coverage due to a HIPAA qualifying event (including getting married, having a child or involuntarily losing my other coverage). If a HIPAA qualifying event occurs and I want ot enroll in other group coverage I know that I must submit proof of other group coverage or my request will not be processed.

Signature (Required)

Applicant	Date (MM/DD/YY)
X	

UNIVERSITY CORPORATION
CSU MONTEREY BAY
Research, Housing and Commercial Services

University Corporation at Monterey Bay

100 Campus Center Bldg 201, Suite119 Seaside, CA 93955

Premium Reduction Election Form

Name: _____

Social Security Number: _____ Date of Hire: _____

You are eligible to participate in the University Corporation at Monterey Bay's employee benefit program after satisfactorily completing your employee benefits waiting period. University Corporation at Monterey Bay sponsors a portion of the cost of the employee benefit coverage and the University Corporation at Monterey Bay Pre-Tax Flexible Benefits Plan allows you to pay for the required employee and dependent contributions (or your portion of the premiums) in the plan on a pre-tax basis.

********* Statement of Understanding *********

I understand that should I decide not to enroll myself and/or my dependents for any benefits for which I am eligible at this time, I may be required to wait until the annual open enrollment (if available) to add any medical coverage, and that dental benefits for late enrollees require a waiting period.

I understand that I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the plan year unless I have change in my family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full-time to part-time, or from part-time to full-time, my spouse or I taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer- sponsored health coverage, or such other events as the Plan Administrator determines will permit a change or revocation of an election).

In lieu of specified compensation, I hereby authorize salary redirection in the amounts of current premiums being charged. I understand that if my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease. The Plan Administrator may redirect or cancel my compensation or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

The redirection in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer. Any amounts that are not used during the plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in the later plan year.

Prior to the first day of each year plan, I will be offered the opportunity to change my benefit elections for the following year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit elections then in effect for the new plan year. In addition, this compensation redirection agreement will continue by its terms in the amount of the required contribution for the benefit option.

As an eligible employee in the above plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan. In accordance with my rights under the Plan, I have elected certain benefits and designated the corresponding amounts for each benefit I have elected for the plan year. The Employer and I agree that my cash compensation will be redirected as set forth above for each month and plan year (or during such portion of the year as remains after the date of this agreement).

This agreement is subject to the terms of the University Corporation at Monterey Bay Pre-Tax Benefits Plan, as amended, in effect, and shall be governed by and construed in accordance with applicable laws and shall take effect as a sealed instrument under applicable law, and revokes any prior election and compensation redirection agreement related to such plan.

Employee Signature: _____ Date: _____

University Corporation at Monterey Bay
Automatic Enrollment
Initial Notice

TIAA CREF 403(b)
Automatic Enrollment and Default Investment
Initial Notice

The University Corporation at Monterey Bay (your "employer") is making saving for retirement under our 403(b) Plan even easier. We are offering an Automatic Enrollment feature!

You are receiving this notice to inform you of the option to change the amount of the contributions coming out of your salary and how such contributions will continue to be invested if you do not provide complete investment instructions. Please disregard this notice if you have already completed and submitted a Salary Deferral Agreement and/or provided complete investment instructions.

If you have not completed and submitted a Salary Deferral Agreement, you will be automatically enrolled in the Plan starting with your first paycheck. This means that amounts will be taken from your pay and contributed to the Plan. For pay during 2020 these automatic contributions will be 6% of your eligible pay each pay period. But, you can choose a different amount. You can choose to contribute more, less, or even nothing.

This notice gives you important information about the Plan's rules, including the Plan's automatic enrollment feature. The notice covers these points:

- **Whether the Plan's automatic enrollment feature applies to you;**
- **What amounts will be automatically taken from your salary and contributed to the Plan;**
- **How your contributions will be invested;**
- **How you can change the investment allocation of your contributions;**
- **Where you can view plan and investment related information;**
- **When your Account will be vested (that is, not forfeited if you leave your job), and when you can withdraw your plan Account balance;**
- **How you can change the amount of your contributions; and**
- **How you can change your beneficiary designation(s)**

Distributions from 403(b) plans before age 59 ½, severance from employment, death, or disability may be prohibited, limited, and/or subject to substantial tax penalties. Different restrictions may apply to other types of plans.

You can find out more about the Plan in the Summary Plan Description (SPD), which is available from the Plan Administrator at the address shown at the end of this notice.

1. Does the Plan's Automatic Enrollment feature apply to me?

The Plan's Automatic Enrollment feature does not apply to you if you already elected (completed and submitted a Salary Deferral Agreement to the Plan Administrator) to make contributions to the Plan or to not contribute. If you made an election of how much you want to contribute, your contribution level will remain the same. You can always change your contribution level by completing and submitting a new Salary Deferral Agreement to the Plan Administrator at the address shown at the end of this notice.

If you have not elected a contribution rate, you will be enrolled in the Plan starting with your first paycheck. This means money will be automatically taken from your salary and contributed to your account. If you do not want to be enrolled, you need to obtain a salary
reduction form from the Plan Administrator at the address shown at the end of this notice, and then submit the completed form to the Plan Administrator indicating your election not to participate.

2. If I do nothing, how much will be taken from my salary and be contributed to the Plan?

If you do not turn in a completed Salary Deferral Agreement immediately or prior to your first pay date, 6% of your eligible salary for each pay period will continue to be taken from your salary and contributed to the Plan. This starts with your first paycheck in 2020 and continues through the end of employment. To learn more about the Plan's definition of eligible salary, you can review the Plan's SPD.

Your contributions to the Plan will be taken out of your salary and are not subject to federal income tax at that time. Instead, they will be contributed to your plan Account and may grow over time with earnings. Your plan account balance will be subject to federal income tax only when amounts are withdrawn. This helpful tax rule is a reason to save for retirement through Plan contributions.

Contributions will be taken out of your salary if you do nothing. But you are in charge of the amount that you contribute. You may decide to do nothing and become automatically enrolled, or you may choose to contribute an amount that better meets your needs. You can change your contributions by completing and submitting a new Salary Deferral Agreement to the Plan Administrator at the address listed at the end of this notice.

If you want to contribute more to your plan account than the Automatic Enrollment percentage, there are limits on the maximum amount. These limits are described in the Plan's summary plan description "SPD," which is available from the Plan Administrator at the address listed at the end of this notice, as well as dictated each year by the IRS.

3. In addition to the contributions taken out of my salary, what amount will The University Corporation contribute to my Account?

The employer contributions to your plan, of 10%, will become yours after you have been employed for 6 months in a benefited status or meet other defined criteria.

4. How will my contributions be invested?

TIAA-CREF has been selected by The University Corporation as the investment provider for the Automatic Enrollment contributions. The Plan lets you invest the contributions in a number of different investment choices. Unless you choose a different investment option or options, the Auto Enroll contributions will be invested in the default investment option for University Corporation at Monterey Bay 403(b) DC Plan which is the ***Blackrock LifePath Index Target date funds***. If the default investment option changes at any time in the future, you will be notified.

You can obtain updated information on fee expenses and a more detailed explanation of the Blackrock LifePath Index Target date funds at https://www.tiaa.org/ or by contacting TIAA CREF at **800 842-2252**.

To learn more about the Plan's investment choices, you can review the Plan's SPD. Also, you can contact the Plan Administrator using the contact information at the end of this notice.

5. How can I change the investment allocation of the contributions that will be made on my behalf by The University Corporation at Monterey Bay to another investment choice available under the plan?

The Plan allows you to choose from a diverse set of investment options. A list of the Plan's available investment options and a copy of the prospectus or information statement for each investment option may be obtained from TIAA-CREF at **800 842-2252** or at https://www.tiaa.org

You have the right to change the allocation of your investments at any time. If you elect to change the allocation of your account from the Blackrock LifePath Index Target date funds, there are no fees or expenses imposed in connection with that transfer. But certain restrictions may apply if multiple transfers are made from any one account. See the fund prospectus at https://www.tiaa.org for more details on restrictions on frequent transfers.

You can change how the contributions are invested among the Plan's offered investment options, by contacting TIAA-CREF at **800 842-2252** or accessing your account online at **tiaa cref.org**.

6. When will my Account be vested and available to me?

You will always be fully vested in your contributions to the Plan. You will also be fully vested in the employer matching contributions when you complete 6 months of service. To be fully vested means that the contributions (together with any investment gain or loss) will always belong to you, and you will not lose them when you leave your job. For more information
about years of service, you can review the Plan's SPD, which can be obtained from the Plan
Administrator at the address listed at the end of this notice.

Even if you are vested in your Account, there are limits on when you may withdraw your funds. These limits may be important to you in deciding how much, if any, to contribute to the Plan. In general, for 403(b) plans you may only withdraw vested money after you leave your job, reach age 59½, or become disabled. Also, there is a 10% federal tax penalty on distributions before age 59½.

7. Can I change the amount of my contributions?

You can change the amount you contribute to the Plan. If you do not want to contribute to the Plan (and you haven't already elected not to contribute), you will want to turn in a Salary Deferral Agreement electing zero contributions (0%)prior to your first paycheck following date of hire.

If you discontinue automatic contributions, The University Corporation will treat you as having chosen to make no further contributions. However, you can always choose to continue or restart your contributions by completing and submitting a new Salary Deferral Agreement to the Plan Administrator at any time during your employment.

8. How can I change my beneficiary designation(s)?

In addition to reviewing how your contributions are invested, you should also review and update your beneficiary designation(s) if it is does not reflect your how you would want your assets distributed upon your death. Reviewing and changing your beneficiary designation(s) in accordance with Plan rules can be made by logging into your secure account at **tiaa-cref.org** or by contacting TIAA-CREF at **800-842-2252**.

9. Who should I call if I have any questions?

If you have any questions about the Plan's investment choices, how the Plan works or your rights and obligations under the Plan, or if you would like a copy of the Plan's SPD or other Plan documents, please contact the Plan Administrator at:

Maddison Burton
Director of Human Resources
University Corporation at Monterey Bay
mburton@csumb.edu
831-582-4498

By signing this form, you acknowledge receipt of the Automatic Enrollment and Default Investment Initial Notice from the University Corporation at Monterey Bay.

I acknowledge receipt of the Automatic Enrollment and Default Investment Initial Notice from the University Corporation at Monterey Bay.

Name: _____
(Employee)

Signature: _____ Date: _____
(Employee)

Signature: _____ Date: _____
(HR Representative)

For Payroll/HR Use Only:

1. Acknowledgement signed
   - ☐ Yes
   - ☐ No

2. Salary Reduction Received
   - ☐ Yes
   - ☐ No – enter 6% in ADP

3. Entered in ADP
   - ☐ Yes – If no selection of different percentage selected
   - ☐ No – If contribution 0%

Date: _____ *Initials:* _____

Personal Information Verification Form

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions, including us, to obtain, verify and record information that identifies each person who opens an account.

What this means for you: When you open an account, we will ask for your name, residence address, date of birth, Social Security number and other information that will allow us to identify you, such as your home telephone number. Until you provide the information we need, we may not be able to open an account or effect any transactions for you.

Please provide the information requested below. Any correspondence will be sent to this mailing address and to this email address. You will receive a follow up email requesting that you create on online account and that you enter your investment selections and beneficiary information online.

Name: _____
Last First Middle

Social Security #: _____ Date of Birth: _____

Residence Address: _____
Street

_____
City State Zip

Home Telephone #: (_____) _____

Email Address: _____

****

HR use:

10% contribution to begin after _____ paydate

☐ *entered in ADP* ☐ *entered in TIAA CREF*

UNIVERSITY CORPORATION
CSU MONTEREY BAY
Research, Housing and Commercial Services

Payroll Deduction Authorization
Payroll Services

Instructions

1. Complete employee information
2. Select deduction type, action, and beginning pay period for all desired deductions
3. Sign & date form
4. *Email to: hr_corporation@csumb.edu*

Employee Information		
OtterID	**First Name**	**Last Name**

Deduction Information							
Deduction Type (select all that apply)		**Deduction Amount monthly**	**Action (select all that apply)**			**Effective Pay Period**	
			New	**Delete**	**Change**	**Month**	**Year**
	Gym Only	$18.00					
	Pool Only	$18.00					
	Gym/Pool	$22.00					
	PreTax-Parking	$14.00					
	Please complete the link*Donation to CSUMB	$					

Date _____ **Employee Signature** _____

Date _____ **Employer Representative Signature** _____

EMPLOYEE FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

EMPLOYER: University Corporation at Monterey Bay	GROUP NUMBER: CSURMA

EMPLOYEE INFORMATION

EMPLOYEE NAME:		SEX: ☐ M ☐ F
DATE OF BIRTH (MM/DD/YYYY):	DATE OF HIRE (MM/DD/YYYY):	ID #/SSN:
EMPLOYEE STREET ADDRESS: ☐ Please check if this is a change in address		
CITY:	STATE:	ZIP:
E-MAIL ADDRESS:	FAX NUMBER:	PHONE:

ELECTION

I ELECT THE FOLLOWING:		Amount Per Pay Period	# of Pay Periods	Annual Election	
				Actual	Maximum
Healthcare Account:	☐ Yes ☐ No	$		$	$ 2,700 Plan Year
Dependent Care Account	☐ Yes ☐ No	$		$	$ 5,000 Calendar Year

Pre-Tax Premium Deductions: health insurance premiums, and all other eligible insurance premiums, will be excluded from taxable income. The employer will automatically apply pre-taxation of these insurance premiums unless you specifically decline the option. If you do not wish to have your insurance premiums pre-taxed, you must notify Human Resources during open enrollment.

QUALIFIED DEPENDENTS

The following lists the IRS qualified dependents whose claims I may request reimbursement for throughout the Plan Year:

LAST NAME	FIRST NAME	RELATIONSHIP TO EMPLOYEE

AUTHORIZATION

By signing this form, I certify the following: 1) I have read the information provided to me on Flexible Benefits. 2) The above information is correct and I authorize the salary reductions as I have indicated. 3) I understand that any amounts remaining in my Health Care Account that are not used for eligible expenses incurred during the plan year may be subject to forfeiture, according to plan provisions and pre-tax laws – see SPD 4) I understand that any amounts remaining in my Dependent Care Account that are not used for eligible expenses incurred during the plan year may not be carried forward, according to plan provisions and pre-tax laws.5)I understand that the elected salary reduction(s) will remain in effect for the Plan Year and can only be changed if I experience a change in my status (e.g. birth, adoption, marriage, divorce, loss or gain of spouse's employment), according to the Summary Plan Document.

☐ Please check this box if you have lost, misplaced, or need a replacement FSA Benefits Card for the new Plan Year. If you currently have an FSA Benefits Debit Card, you do not need a new one. Your current card will be "re-loaded" at the start of the new Plan Year.

EMPLOYEE SIGNATURE (Required) _____ DATE _____

INFORMATION SUPPLIED BY EMPLOYER:

Frequency of Pay:	☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly	☐ Monthly	☐ Other
First Pay Date of Deductions:			Division/Location:		
Effective Date Of Coverage:					

Managing your reimbursement account has never been easier! For instant access to your account, register with My SmartCare's online portal at https://www.mywealthcareonline.com/bccsmartcare/ or download the free My SmartCare mobile app from your Apple or Android device.

GROUP BENEFITS FROM THE HARTFORD

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

THE HARTFORD

ENROLLMENT FORM

EMPLOYER INFORMATION	EMPLOYER'S FULL LEGAL NAME University Corporation at CSU Monterey Bay		GROUP POLICY# 402909	
ENROLLMENT INFORMATION	Please check one of the following:			
	■ INITIAL ENROLLMENT		EFFECTIVE DATE:	
	☐ CHANGE TO EXISTING ENROLLMENT		EFFECTIVE DATE:	
	☐ FAMILY STATUS CHANGE (TYPE):		EFFECTIVE DATE:	
EMPLOYEE INFORMATION	EMPLOYEE NAME	DATE OF BIRTH	EMPLOYEE ID/SSN	DATE OF HIRE
	ADDRESS	CITY	STATE / ZIP CODE	GENDER ☐M ☐F
	SPECIALTY/OCCUPATION	EARNINGS (AS DEFINED BY THE POLICY) $ ☐HR ☐MO ☐YR	# HOURS WORKED PER WEEK	LOCATION UCorp

DEPENDENT INFORMATION	SPOUSE'S NAME	GENDER ☐M ☐F	DATE OF BIRTH	DATE OF MARRIAGE
	CHILD'S NAME	GENDER ☐M ☐F	DATE OF BIRTH	
	CHILD'S NAME	GENDER ☐M ☐F	DATE OF BIRTH	
	CHILD'S NAME	GENDER ☐M ☐F	DATE OF BIRTH	

APPLICABLE BENEFIT ELECTIONS	Please make your benefit elections by checking the appropriate box. Contact your employer for plan details.			
	SHORT TERM DISABILITY	☐ YES	■ NO	COST: n/a
	For **DISABILITYFLEX**℠ choose:	WEEKLY BENEFIT CHOICE $ n/a	BENEFIT DURATION n/a	BENEFIT COMMENCEMENT PERIOD n/a
	LONG TERM DISABILITY	■ YES	☐ NO	COST: n/a
	CRITICAL ILLNESS	☐ EMPLOYEE $ n/a	☐ EMPLOYEE AND CHILD(REN) $ n/a	■ NO
	TOBACCO USER ☐ YES ☐ NO	☐ EMPLOYEE AND SPOUSE $ n/a	☐ EMPLOYEE AND FAMILY $ n/a	COST: n/a
	BASIC LIFE AND AD&D*			
	EMPLOYEE	■ YES $ 50,000.00	☐ NO	COST: ER paid
	SPOUSE	☐ YES $	■ NO	COST:
	CHILD	☐ YES $	■ NO	COST:
	*If applicable, the accidental death benefit (AD&D) will equal the face amount of the life insurance elected.			
	SUPPLEMENTAL LIFE AND AD&D*			
	EMPLOYEE	☐ YES $	☐ NO	COST:
	SPOUSE	☐ YES $	☐ NO	COST:
	CHILD	☐ YES $	☐ NO	COST:
	*If applicable, the accidental death benefit (AD&D) will equal the face amount of the life insurance elected.			
	SUPPLEMENTAL AD&D			
	EMPLOYEE	☐ YES $	☐ NO	COST:
	SPOUSE	☐ YES $	☐ NO	COST:
	CHILD	☐ YES $	☐ NO	COST:

APPLICABLE BENEFIT ELECTIONS CONTINUED				
	ACCIDENT	☐ EMPLOYEE	☐ EMPLOYEE AND SPOUSE	■ NO
	PLAN OPTION: n/a	☐ EMPLOYEE AND CHILD(REN)	☐ EMPLOYEE AND FAMILY	COST: n/a

BENEFICIARY INFORMATION

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you. A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

PRIMARY BENEFICIARY

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

CONTINGENT BENEFICIARY

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

Consent For Community Property States Only: If you live in a community property state – **Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin** – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. **Disclaimer:** Spousal consent does not apply to ERISA plans. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will represent that, as spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

SIGNATURE OF EMPLOYEE'S SPOUSE	DATE

CONFIRMATION	I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford. I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy. If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition. If I have critical illness insurance coverage with The Hartford, I understand and agree that my critical illness insurance benefit is terminated at a specified age stated in the policy and that a claim for benefits may not be approved for a pre-existing condition. I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force. **Fraud Notice(s)** **For Residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **For Residents of Louisiana and Maryland:** Any person who knowingly (knowingly or willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly or willfully in Maryland) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For Residents of New York (Not applicable to Life Insurance):** **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.** **For Residents of Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
	SIGNED | DATE

Dear: University Corporation Staff,

You work hard for your paycheck, and we'd like to help you protect it.

We know that life is a balancing act. It's about standing up to the expected and unexpected every day. For 60 years, we've been dedicated to helping people protect their financial security and peace of mind when they've needed it most.

While you can't possibly foresee everything that can come your way, you can make smart choices so you are better prepared for things life can throw at you. That's why I'd like to talk to you about Aflac insurance.

Aflac is different from health insurance; it's insurance for daily living. While major medical insurance pays doctors and hospitals, Aflac pays cash benefits directly to you. Benefits are paid regardless of any other coverage you may have – even workers,' compensation. And because we want you to be able to focus on getting better and not worry about how you will pay the unexpected medical bills or other everyday living expense such as rent/mortgage payments, we focus on getting you cash as quickly as possible. Most claims are paid within four days. You use the money however you see fit.

When you have an Aflac policy, it belongs to you, not the University. You own it!

Our Aflac Representative Lesleigh Schmidt will be reaching out to you to schedule an appointment to educate you about the program.

Maddison Burton
Director of Human Resources