

**Test Plan**  
**RELEASE 1701**

**COBRA Election Notice IDOCs**

Baskar Chitravel  
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Application Technology Services  
Information Resources & Computing  
Office of the President  
University of California

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## Testing Overview

This test plan addresses the test runs and cases constructed to verify the correct installation of Release 1701. The test is made up of the following components:

1. Control Table Data Base (CTL) Initial Load (LOADCTL)
2. Employee Data Base (EDB) Initial Load (LOADEDDB)
3. Load Infrastructure Tables UC0CFN & UC0PFK (LOADPCDX)
4. LOAD Data Dictionary for Screen Level Help (LOADSCRN)
5. Test CICS Screen IDOC and Program PPWIDOC
6. Test CICS Screen IPPA and Program PPWIPPA
7. Test the COBRA Notification IDOCs and Program PPDXCOBR
8. Attachments -- Sample COBRA Notification Document

## CONTROL TABLE (CTL) INITIAL LOAD (LOADCTL)

### **Description**

This job loads the DB2 CTL database.

If there are any Control Table Transaction updates for this release, the Control Table Transaction updates are already reflected in the particular PDS members used for the loading of the DB2 CTL database.

### **Verification**

Ensure that the DB2 CTL has been successfully restored by verifying normal completion of the job and ensuring that all tables have been successfully loaded into the database.

## EMPLOYEE DATA BASE (EDB) INITIAL LOAD (LOADEDDB)

### **Description**

This job loads the EDB database.

### **Verification**

In order to assure successful completion of this job, verify that the EDB has been successfully restored by verifying normal completion of the job and ensuring that all tables have been successfully loaded into the database.

## LOAD INFRASTRUCTURE TABLES UC0CFN & UC0PFK (LOADPCDX)

### Description

This job loads the UC function code table UC0CFN and the UC Aid Key Assignments table UC0PFK. Please note that all base **Changed By** and **Changed At** values should be substituted with your own Changed By and Changed At before loading into the UC0CFN and UC0PFK tables. Also use LOAD RESUME option which will not replace your current INFRASTRUCTURE entries.

### Verification

In order to assure successful completion of this job, verify that the UC0CFN & UC0PFK tables have been successfully restored by verifying normal completion of the job and ensuring that all tables have been successfully loaded into the database.

## LOAD Data Dictionary for Screen Level Help (LOADSCRN)

### Description

The steps used for loading screen level help data dictionary are:

1. Go to CICS and enter the command CEMT INQ FI(D21HLP2).
2. Change the status of this file from 'OPE' to 'CLO' and then press Enter.
3. Submit the JCL LOADSCRN which loads these new help definitions to the CICS Help file.
4. Now Go to CICS again and enter the command CEMT INQ FI(D21HLP2).
5. Change the status of this file from 'CLO' to 'OPE' and then press Enter.

### Verification

In order to assure successful completion of this job, verify that the LOADSCRN has been successfully restored by verifying normal completion of the job and ensuring that DOCHIPPA screen help is shown on the PPIPPA0 screen.

## Test CICS Screen IDOC and Program PPWIDOC

### Description

Test the addition of COBRA Notification Documents selection line to the on-line CICS screen IDOC. IDOC CICS screen is accessed by the EDB On-line Inquiry program PPWIDOC.

After successful installation of the CICS program PPWIDOC, make a newcopy in the region you are going to test the IDOC screen. After successful newcopy, select the employee ID 000050101 with option IDOC in the PPS CICS system. The IDOC screen will look like the one shown below. Verify in this screen that the correct release number is displayed in the top left corner of the screen (PPIDOC0-I1701), where 1701 is the release number.

```
PPIDOC0-I1701      Employee Documents      04/04/06 11:49:35
03/21/06 18:41:38      Document Selection Menu      Userid: PAYBCC
ID: 000050101 Name: MANDER,SALLY      Emp Stat: A      Pri Pay: MO
Page 1 of 2

New Hire or Re-Hire Documents:      - Staff
                                      - Academic
                                      - Student

Change-in-Status Documents :      - Staff
                                      - Academic
                                      - Student

Leave/Sabbatical Documents :      - Staff-Leave
                                      - Academic-Leave/Sabbatical
```

Press PF8 to go to the next page. The next page of the IDOC screen will look like the one shown below. Verify in this screen the following:

1. Verify that the correct release number is displayed in the top left corner of the screen (PPIDOC0-I1701), where 1701 is the release number.
2. Verify that there is a last line to select **All** of the **COBRA Notification documents**.
3. Verify that there is no one character selection display after the COBRA Notification line. This extra selection display is removed in this release.

```
PPIDOC0-I1701      Employee Documents      04/04/06 11:51:48
03/21/06 18:41:38      Document Selection Menu      Userid: PAYBCC
ID: 000050101 Name: MANDER,SALLY      Emp Stat: A      Pri Pay: MO
Page 2 of 2

Separation Documents      :      - Staff
                        :      - Academic
                        :      - Student
                        :      - Layoff

Personnel Summary Documents :      - All - Landscape
                        :      - All - Portrait

Benefits Summary Documents :      - Benefits Enrollment
                        :      - Retirement and Savings

COBRA Notification Documents :      - All
```

## Test CICS Screen IPPA and Program PPWIPPA

### Description

Test the addition of COBRA Notification Documents selection format labels to the on-line CICS screen IPPA. IPPA CICS screen is accessed by the EDB On-line Inquiry program PPWIPPA.

After successful installation of the CICS program PPWIPPA, make a newcopy in the region you are going to test the IPPA screen. After successful newcopy, select the employee ID 000050101 with option IDOC in the PPS CICS system. The first page of the IDOC screen is displayed. Press PF8 to go to the next page.

Type 'S' in the selection field of the **COBRA Notification documents**. Press PF5 to go to the IPPA screen that lists all the COBRA documents selection. The IPPA screen will look like the one shown below. Verify in this screen the following:

1. Verify that the correct release number is displayed in the top left corner of the screen (PPIPPA0-I1701), where 1701 is the release number.
2. Verify that the message number "P0652" with the text "Select one action" is displayed at the bottom of this screen.

```
PPIPPA0-I1701      Employee Documents      04/04/06 12:43:50
03/21/06 18:41:38      COBRA Notification Actions      Userid: PAYBCC
ID: 000050101 Name: MANDER, SALLY      Emp Stat: A      Pri Pay: MO
                                           Page 1 of 1

COBRA Notification Documents:
- Separation
- Layoff
- Retirement
- Reduction of Hours
- Approved Leave without Pay

Next Func: _____ ID: _____ Name: _____ SSN: _____
P0652 Select one action
```

3. Verify that all the **COBRA Notification documents** (Separation, Layoff, Retirement, Reduction of hours, and Approved Leave without pay) are listed with their selection fields.
4. Verify that there is no one character selection display after the “Approved Leave without Pay” line. This extra selection display in the IPPA screen is removed in this release.

Type ‘S’ in the selection fields of **Separation** and **Layoff** COBRA documents and press Enter key. Verify in this screen that the message number “**P0646**” with the text “**Only one selection permitted**” is displayed at the bottom of this screen. Also, notice that selection **Layoff** is highlighted in red.

```
PPIPPA0-IRRRR      Employee Documents      04/07/06 10:47:14
03/21/06 18:41:38      COBRA Notification Actions      Userid: PAYBCC
ID: 000050101 Name: MANDER,SALLY      Emp Stat: A      Pri Pay: MO
Page 1 of 1

COBRA Notification Documents:  S Separation
                               S Layoff
                               - Retirement
                               - Reduction of Hours
                               - Approved Leave without Pay

Next Func: _____ ID: _____ Name: _____ SSN: _____
P0646 Only one selection permitted
```

Now, type 'S' only in the selection field of **Separation** COBRA document. Press PF5 to print the selected document. Verify that second page of IDOC screen is displayed and the message number "P0649" with the text "Document(s) printed" is displayed at the bottom of this screen as shown below. Also, notice that there is a "\*" in the COBRA selection.

```
PPIDOC0-IRRRR      Employee Documents      04/07/06 10:56:53
03/21/06 18:41:38      Document Selection Menu      Userid: PAYBCC
ID: 000050101 Name: MANDER,SALLY      Emp Stat: A      Pri Pay: MO
Page 2 of 2

Separation Documents      :      - Staff
                          :      - Academic
                          :      - Student
                          :      - Layoff

Personnel Summary Documents :      - All - Landscape
                          :      - All - Portrait

Benefits Summary Documents :      - Benefits Enrollment
                          :      - Retirement and Savings

COBRA Notification Documents :      * All

Next Func: _____ ID: _____ Name: _____ SSN: _____
P0649 Document(s) printed
```

Now the **Separation** COBRA document for this employee is printed. Check the printer for this document.

Press PF5 again after selecting 'S' in the **COBRA Notification** selection. After going to the IPPA screen, press PF3 to exit the IPPA screen. Now the IDOC screen is displayed. This test verifies that the **PF3** exit key in the IPPA screen for COBRA documents is working properly (tests the addition of a 'STACK-RETURN' PF3 label row to the UC0PFK infrastructure table for the IPPA to IDOC PF3 key interface).

## Test the COBRA Notification IDOCs and Program PPDXCOBR

### Description

Test the new IDOC program PPDXCOBR which generates texts for all the COBRA Notification Documents.

After successful installation of the DUAL program PPDXCOBR, make a newcopy in the region you are going to test the COBRA documents printing. After successful newcopy, select the employee ID 888000562 with option IDOC in the PPS CICS system. The first page of the IDOC screen is displayed. Press PF8 to go to the next page.

### Test Separation COBRA Notification IDOC

Type 'S' in the selection field of the **COBRA Notification documents**. Press PF5 to go to the IPPA screen that lists all the COBRA documents selection. Now, type 'S' only in the selection field of **Separation** COBRA document. Press PF5 to print the selected document. Verify that second page of IDOC screen is displayed and the message number "**P0649**" with the text "**Document(s) printed**" is displayed at the bottom of this screen with a '\*' in the COBRA selection. Now the **Separation** COBRA document for this employee is printed. Check the printer for this document. The employee copy of the sample document is attached in the **attachment A**.

Verify in this document the following:

1. Page numbers are printed properly (1 of 3, 2 of 3, and 3 of 3).
2. Date of the document should be the current date.
3. There are duplicate copies of this separation COBRA document. Third page of the first copy has a footer of "Employee Copy" and the second copy's third page has a footer of "Retention By Benefits Office/Department". Also, make sure that there is no wording change between the first and the second copies of this separation COBRA IDOC.
4. The qualifying event line is printed as follows:  
Termination of Employment on: 04/15/06
5. The application due date is 60 days from the current date.
6. Medical coverage termination is 05/31/06. Plan is Kaiser North with Self Coverage.
7. Dental coverage termination is 05/31/06. Plan is Delta Dental with Self Coverage.
8. Vision coverage termination is 05/31/06. Plan is Vision Services Plan with Self Coverage.
9. Qualified beneficiaries table contains only employee line. This employee has Medical coverage "Yes", Dental Coverage "Yes", and Vision Coverage "Yes".
10. COBRA Begin Date in the 2<sup>nd</sup> page is 06/01/06 (one day after Medical Coverage End Date of 05/31/06).

Note: This test needs the run date to be less than or equal to 05/31/06 for the medical, dental, and vision coverages to be selected for the separation document.

## Test Layoff COBRA Notification IDOC

For the same employee ID 888000562, type 'S' in the selection field of the **COBRA Notification documents**. Press PF5 to go to the IPPA screen that lists all the COBRA documents selection. Now, type 'S' only in the selection field of **Layoff COBRA** document. Press PF5 to print the selected document. Verify that second page of IDOC screen is displayed and the message number "**P0649**" with the text "**Document(s) printed**" is displayed at the bottom of this screen with a '\*' in the COBRA selection. Now the **Layoff COBRA** document for this employee is printed. Check the printer for this document. The employee copy of the sample document is attached in the **attachment B**.

Verify in this document the following:

1. Page numbers are printed properly (1 of 3, 2 of 3, and 3 of 3).
2. Date of the document should be the current date.
3. There are duplicate copies of this layoff COBRA document. Third page of the first copy has a footer of "Employee Copy" and the second copy's third page has a footer of "Retention By Benefits Office/Department". Also, make sure that there is no wording change between the first and the second copies of this layoff COBRA IDOC.
4. The qualifying event line is printed as follows:  
Layoff on: 04/15/06
5. The application due date is 60 days from the current date.
6. Medical coverage termination is 05/31/06. Plan is Kaiser North with Self Coverage.
7. Dental coverage termination is 05/31/06. Plan is Delta Dental with Self Coverage.
8. Vision coverage termination is 05/31/06. Plan is Vision Services Plan with Self Coverage.
9. Qualified beneficiaries table contains only employee line. This employee has Medical coverage "Yes", Dental Coverage "Yes", and Vision Coverage "Yes".
10. COBRA Begin Date in the 2<sup>nd</sup> page is 06/01/06 (one day after Medical Coverage End Date of 05/31/06).

Note: This test needs the run date to be less than or equal to 05/31/06 for the medical, dental, and vision coverages to be selected for the layoff document.

## Test Retirement COBRA Notification IDOC

For the same employee ID 888000562, type 'S' in the selection field of the **COBRA Notification documents**. Press PF5 to go to the IPPA screen that lists all the COBRA documents selection. Now, type 'S' only in the selection field of **Retirement COBRA** document. Press PF5 to print the selected document. Verify that second page of IDOC screen is displayed and the message number "P0649" with the text "**Document(s) printed**" is displayed at the bottom of this screen with a '\*' in the COBRA selection. Now the **Retirement COBRA** document for this employee is printed. Check the printer for this document. The employee copy of the sample document is attached in the **attachment C**.

Verify in this document the following:

1. Page numbers are printed properly (1 of 3, 2 of 3, and 3 of 3).
2. Date of the document should be the current date.
3. There are duplicate copies of this retirement COBRA document. Third page of the first copy has a footer of "Employee Copy" and the second copy's third page has a footer of "Retention By Benefits Office/Department". Also, make sure that there is no wording change between the first and the second copies of this retirement COBRA IDOC.
4. The qualifying event line is printed as follows:  
Retirement on: 04/15/06
5. The note in the retirement IDOC which is different from the other type of COBRA IDOCS after the qualifying event line is printed as follows:

-----  
Note: If you are eligible and have made arrangements to continue your UC-sponsored medical or dental coverage into retirement, and you are not enrolled in the vision plan or do not wish to continue your vision coverage under COBRA, please disregard this mailing. However, if you are enrolled in the vision plan and wish to continue your vision coverage under COBRA, use this form to apply. (Vision coverage through UC is not available to retirees.)  
-----

6. The application due date is 60 days from the current date.
7. Medical coverage termination is 05/31/06. Plan is Kaiser North with Self Coverage.
8. Dental coverage termination is 05/31/06. Plan is Delta Dental with Self Coverage.
9. Vision coverage termination is 05/31/06. Plan is Vision Services Plan with Self Coverage.
10. Qualified beneficiaries table contains only employee line. This employee has Medical coverage "Yes", Dental Coverage "Yes", and Vision Coverage "Yes".
11. COBRA Begin Date in the 2<sup>nd</sup> page is 06/01/06 (one day after Medical Coverage End Date of 05/31/06).

Note: This test needs the run date to be less than or equal to 05/31/06 for the medical, dental, and vision coverages to be selected for the retirement document.

## Test Reduction of Hours COBRA Notification IDOC

For the employee ID 888000101, type 'S' in the selection field of the **COBRA Notification documents**. Press PF5 to go to the IPPA screen that lists all the COBRA documents selection. Now, type 'S' only in the selection field of **Reduction of Hours** COBRA document. Press PF5 to print the selected document. Verify that second page of IDOC screen is displayed and the message number "**P0649**" with the text "**Document(s) printed**" is displayed at the bottom of this screen with a '\*' in the COBRA selection. Now the **Reduction of Hours** COBRA document for this employee is printed. Check the printer for this document. The employee copy of the sample document is attached in the **attachment D**.

Verify in this document the following:

1. Page numbers are printed properly (1 of 3, 2 of 3, and 3 of 3).
2. Date of the document should be the current date.
3. There are duplicate copies of this Reduction of Hours COBRA document. Third page of the first copy has a footer of "Employee Copy" and the second copy's third page has a footer of "Retention By Benefits Office/Department". Also, make sure that there is no wording change between the first and the second copies of this Reduction of Hours COBRA IDOC.
4. The qualifying event line is printed as follows:  
Reduction of Hours on: 05/01/06
5. The application due date is 60 days from the current date.
6. Vision coverage termination is 05/31/06. Plan is Vision Services Plan with Family Coverage.
7. Qualified beneficiaries table contains one employee line and two dependent lines. The employee line and the dependent lines have Medical coverage "No", Dental Coverage "No", and Vision Coverage "Yes".
8. COBRA Begin Date in the 2<sup>nd</sup> page is 06/01/06 (one day after Vision Coverage End Date of 05/31/06).

Note: This test needs the run date to be less than or equal to 05/31/06 for the vision coverage to be selected for the Reduction of Hours document.

## Test Approved Leave without Pay COBRA Notification IDOC

For the employee ID 888000111, type 'S' in the selection field of the **COBRA Notification documents**. Press PF5 to go to the IPPA screen that lists all the COBRA documents selection. Now, type 'S' only in the selection field of **Approved Leave without Pay** COBRA document. Press PF5 to print the selected document. Verify that second page of IDOC screen is displayed and the message number "**P0649**" with the text

“**Document(s) printed**” is displayed at the bottom of this screen with a “\*” in the COBRA selection. Now the **Approved Leave without Pay** COBRA document for this employee is printed. Check the printer for this document. The employee copy of the sample document is attached in the **attachment E**.

Verify in this document the following:

1. Page numbers are printed properly (1 of 3, 2 of 3, and 3 of 3).
2. Date of the document should be the current date.
3. There are duplicate copies of this Approved Leave without Pay COBRA document. Third page of the first copy has a footer of “Employee Copy” and the second copy’s third page has a footer of “Retention By Benefits Office/Department”. Also, make sure that there is no wording change between the first and the second copies of this Approved Leave without Pay COBRA IDOC.
4. The qualifying event line is printed as follows:  
Leave without pay on: 04/15/06
5. The note in the Leave without Pay IDOC which is different from the other type of COBRA IDOCS after the qualifying event line is printed as follows:

---

Note: If you are an employee taking a leave without pay and you have arranged to continue your UC-sponsored coverage by making direct payments to your Benefits or Payroll Office instead of electing COBRA continuation, this packet serves as your official notice regarding your COBRA continuation coverage rights.

---

6. The application due date is 60 days from the current date.
7. Medical coverage termination is 05/31/06. Plan is Blue Cross Plus with Self Coverage.
8. Vision coverage termination is 05/31/06. Plan is Vision Services Plan with Self Coverage.
9. Qualified beneficiaries table contains one employee line. The employee line has Medical coverage “Yes”, Dental Coverage “No”, and Vision Coverage “Yes”.
10. COBRA Begin Date in the 2<sup>nd</sup> page is 06/01/06 (one day after Medical Coverage End Date of 05/31/06).

Note: This test needs the run date to be less than or equal to 05/31/06 for the Medical coverage to be selected for the Approved Leave without Pay document.

## Attachments

### Attachment A: Sample COBRA Notification Separation Document

DATE: 04/20/06

Page 1 of 3

UNIVERSITY OF CALIFORNIA  
PAYROLL/PERSONNEL SYSTEM

TO: BLOOM, ORLANDO  
165 PERALTA AVENUE  
SAN FRANCISCO CA, 94110

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Termination of Employment on: 04/15/06

To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 06/19/06

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

#### INSTRUCTIONS

-----  
To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.  
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.
5. Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.
6. Keep a copy of the form for your records.

-----  
1. CURRENT COVERAGE AND DATE COVERAGE ENDS  
-----

The health plan(s) in which you are currently enrolled are indicated below.

Kaiser North  
Self Coverage  
Coverage termination date: 05/31/06

Delta Dental  
Self Coverage  
Coverage termination date: 05/31/06

Vision Services Plan  
Self Coverage  
Coverage termination date: 05/31/06

-----  
2. QUALIFIED BENEFICIARIES  
-----

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- \* Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- \* Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
ORLANDO BLOOM SSN ( )	( ) 01/15/70	M	Employee	Yes( )	Yes( )	Yes( )

If you elect COBRA continuation coverage, your coverage will begin on: 06/01/06

-----  
3. SIGNATURES  
-----

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

-----  
COBRA Continuation Applicant Signature

-----  
Date

-----  
Print Name

( )  
-----  
Daytime phone



## Attachment B: Sample COBRA Notification Layoff Document

DATE: 04/20/06  
Page 1 of 3

UNIVERSITY OF CALIFORNIA  
PAYROLL/PERSONNEL SYSTEM

TO: BLOOM, ORLANDO  
165 PERALTA AVENUE  
SAN FRANCISCO CA, 94110

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Layoff on: 04/15/06

To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 06/19/06

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

### INSTRUCTIONS

-----  
To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.  
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.
5. Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.
6. Keep a copy of the form for your records.

-----  
1. CURRENT COVERAGE AND DATE COVERAGE ENDS  
-----

The health plan(s) in which you are currently enrolled are indicated below.

Kaiser North  
Self Coverage  
Coverage termination date: 05/31/06

Delta Dental  
Self Coverage  
Coverage termination date: 05/31/06

Vision Services Plan  
Self Coverage  
Coverage termination date: 05/31/06

-----  
2. QUALIFIED BENEFICIARIES  
-----

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- \* Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- \* Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
ORLANDO BLOOM SSN (                    )	(   ) 01/15/70	M	Employee	Yes(   )	Yes(   )	Yes(   )

If you elect COBRA continuation coverage, your coverage will begin on: 06/01/06

-----  
3. SIGNATURES  
-----

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

-----  
COBRA Continuation Applicant Signature

-----  
Date

-----  
Print Name

(       )  
-----  
Daytime phone



## Attachment C: Sample COBRA Notification Retirement Document

DATE: 04/20/06  
Page 1 of 3

UNIVERSITY OF CALIFORNIA  
PAYROLL/PERSONNEL SYSTEM

TO: BLOOM, ORLANDO  
165 PERALTA AVENUE  
SAN FRANCISCO CA, 94110

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Retirement on: 04/15/06

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Note: If you are eligible and have made arrangements to continue your UC-sponsored medical or dental coverage into retirement, and you are not enrolled in the vision plan or do not wish to continue your vision coverage under COBRA, please disregard this mailing. However, if you are enrolled in the vision plan and wish to continue your vision coverage under COBRA, use this form to apply. (Vision coverage through UC is not available to retirees.)  
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To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 06/19/06

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

### INSTRUCTIONS

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To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.  
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.

- 5. Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.
- 6. Keep a copy of the form for your records.

-----  
 1. CURRENT COVERAGE AND DATE COVERAGE ENDS  
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The health plan(s) in which you are currently enrolled are indicated below.

Kaiser North  
 Self Coverage  
 Coverage termination date: 05/31/06

Delta Dental  
 Self Coverage  
 Coverage termination date: 05/31/06

Vision Services Plan  
 Self Coverage  
 Coverage termination date: 05/31/06

-----  
 2. QUALIFIED BENEFICIARIES  
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Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- \* Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- \* Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
ORLANDO BLOOM SSN (                    )	(   ) 01/15/70	M	Employee	Yes(   )	Yes(   )	Yes(   )

If you elect COBRA continuation coverage, your coverage will begin on: 06/01/06

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 3. SIGNATURES  
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I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

-----  
COBRA Continuation Applicant Signature

-----  
Date

-----  
Print Name

(     )  
-----  
Daytime phone

-----  
Benefits Representative Signature

-----  
Date

-----  
Campus

(     )  
-----  
Phone

-----  
-----  
ALTERNATE ADDRESS INFORMATION

If any qualified beneficiary electing continuation coverage lives at an address other than the one listed on page 1, provide his/her name and address below to notify your plan carrier(s).

-----  
Print Name

-----  
Mailing Address (Number, Street, City, State, ZIP)

Employee Copy

**Attachment D: Sample COBRA Notification Reduction of Hours Document**

DATE: 04/21/06  
Page 1 of 3

UNIVERSITY OF CALIFORNIA  
PAYROLL/PERSONNEL SYSTEM

TO: KEEPER, FRANCIS K.  
99 OAK ST.  
FREMONT CA, 94555

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Reduction of Hours on: 05/01/06

To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 06/20/06

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

INSTRUCTIONS

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To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.  
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.
5. Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.
6. Keep a copy of the form for your records.

-----  
1. CURRENT COVERAGE AND DATE COVERAGE ENDS  
-----

The health plan(s) in which you are currently enrolled are indicated below.

Vision Services Plan  
Family Coverage  
Coverage termination date: 05/31/06

-----  
2. QUALIFIED BENEFICIARIES  
-----

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- \* Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- \* Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
FRANCIS K. KEEPER SSN ( )	( ) 01/01/60	F	Employee	No	No	Yes( )
B. B. KEEPER SSN ( )	( ) 10/15/56	M	Spouse	No	No	Yes( )
C. C. KEEPER SSN ( )	( ) 02/01/04	M	Child	No	No	Yes( )

If you elect COBRA continuation coverage, your coverage will begin on: 06/01/06

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3. SIGNATURES  
-----

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

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COBRA Continuation Applicant Signature

-----  
Date

( )

-----  
Print Name

-----  
Daytime phone

-----  
Benefits Representative Signature

-----  
Date

-----  
Campus

(     )  
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Phone

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-----  
ALTERNATE ADDRESS INFORMATION

If any qualified beneficiary electing continuation coverage lives at an address other than the one listed on page 1, provide his/her name and address below to notify your plan carrier(s).

-----  
Print Name

-----  
Mailing Address (Number, Street, City, State, ZIP)

## Attachment E: Sample COBRA Notification Approved Leave without Pay Document

DATE: 04/21/06  
Page 1 of 3

UNIVERSITY OF CALIFORNIA  
PAYROLL/PERSONNEL SYSTEM

TO: COOPER, BRAD N.  
99 OAK ST.  
OAKLAND CA, 94607

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Leave without pay on: 04/15/06

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Note: If you are an employee taking a leave without pay and you have arranged to continue your UC-sponsored coverage by making direct payments to your Benefits or Payroll Office instead of electing COBRA continuation, this packet serves as your official notice regarding your COBRA continuation coverage rights.  
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To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 06/20/06

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

### INSTRUCTIONS

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To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.  
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.
5. Make photocopies of all pages of this completed Application for COBRA

Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.

6. Keep a copy of the form for your records.

-----  
1. CURRENT COVERAGE AND DATE COVERAGE ENDS  
-----

The health plan(s) in which you are currently enrolled are indicated below.

Blue Cross Plus  
Self Coverage  
Coverage termination date: 05/31/06

Vision Services Plan  
Self Coverage  
Coverage termination date: 05/31/06

-----  
2. QUALIFIED BENEFICIARIES  
-----

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- \* Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- \* Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
BRAD N. COOPER SSN ( )	( ) 01/01/60	F	Employee	Yes( ) No		Yes( )

If you elect COBRA continuation coverage, your coverage will begin on: 06/01/06

-----  
3. SIGNATURES  
-----

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

-----  
COBRA Continuation Applicant Signature

-----  
Date

----- ( ) -----  
Print Name Daytime phone

-----  
Benefits Representative Signature Date

----- ( ) -----  
Campus Phone

-----  
-----

ALTERNATE ADDRESS INFORMATION

If any qualified beneficiary electing continuation coverage lives at an address other than the one listed on page 1, provide his/her name and address below to notify your plan carrier(s).

-----  
Print Name

-----  
Mailing Address (Number, Street, City, State, ZIP)