

ASE/GSR Child Dependent Health Premium Benefit Program

The University of California's Graduate Student Researchers (GSRs) and Academic Student Employees (ASEs) represented by the United Auto Workers (UAW) are eligible for a remission for their child dependents through a program established in the ASE/GSR collective bargaining agreement (CBA) between UC and the UAW.

Program Overview

GSRs and ASEs employed in a qualifying appointment(s) are eligible to receive a 100% premium remission for child dependents enrolled in UC SHIP, provided the GSR/ASE's income exceeds the designated Medi-Cal eligibility threshold as specified in the collective bargaining agreement.

If the GSR/ASE has a spouse, and their combined household income does not exceed twice the designated Medi-Cal eligibility threshold, the employee is eligible for the child dependent premium remission.

The GSR/ASE is responsible for determining and attesting to eligibility per the criteria below.

The benefits described in this document follow the parties' CBA. The CBA is the controlling documents, and this program overview is not meant to replace or contradict the language that is contained in the CBA or applicable University policy and is not a substitute for reviewing contract articles carefully. This program overview will be interpreted as consistent with the CBA and, in the event of a conflict, the language of the CBA or applicable policy will control.

Eligibility

For this program, eligibility is as follows:

1. The GSR/ASE is eligible to receive a health insurance premium remission under the CBA through a GSR/ASE appointment, or through a combination of GSR and ASE appointments.
2. The GSR/ASE is a registered graduate student with GSR/ASE appointment(s) totaling 25% or more of full-time for a given term in a State-supported or Self-Supporting Program.
3. The GSR/ASE's income exceeds the designated Medi-Cal eligibility threshold.
 - a. If the GSR/ASE has a spouse, and their combined household income does not exceed twice the designated Medi-Cal eligibility threshold then the employee is eligible for the child dependent premium remission.
 - b. Information about Medi-Cal eligibility can be found here:
<https://www.dhcs.ca.gov/Medi-Cal/Pages/qualify.aspx>
4. The GSR/ASE enrolls eligible child dependents in UC SHIP. Eligible child dependents are defined by UC SHIP plan regulations.

Procedures for Receiving Benefit

The GSR/ASE must follow the procedures for remission/reimbursement as defined by their specific location, which may include submission of the ASE/GSR Child Dependent Health Premium Benefit Program Form.

Child Dependent Health Insurance Attestation Form

If you are an Academic Student Employee (ASE) or Graduate Student Researcher (GSR) represented by the United Auto Workers (UAW), use this form to request remission/reimbursement for your child dependent's health insurance premium pursuant to Article 14 – Health Benefits of the ASE/GSR collective bargaining agreement, UC SHIP regulations, and the procedures established at your location.

Once completed, please return the completed Form and any other required documents to your department administrator or designated campus office. Check your location's procedures for additional information on timeline for submission and any additional verification requirements.

Only one Form is needed per quarter/semester, however, you will need to submit a new Form for each quarter/semester in which you are requesting remission/reimbursement.

Employee Information

First and Last Name: _____

Employee ID: _____

Email Address: _____

Appointment Information - Please complete all fields below for each applicable appointment during the quarter/semester in which you are enrolling a qualifying dependent.

Appointment 1:

Quarter/Semester: _____

Job Title: _____

Percentage FTE: _____

Begin Date of Appointment: _____

End Date of Appointment: _____

Department: _____

Appointment 2 (if applicable):

Quarter/Semester: _____

Job Title: _____

Percentage FTE: _____

Begin Date of Appointment: _____

End Date of Appointment: _____

Department: _____

Attestation of Eligibility

Please select all of the following that apply for you during the quarter/semester in which you are enrolling child dependents in UC SHIP.

- I am an Academic Student Employee (ASE) and/or a Graduate Student Researcher (GSR) who is eligible to receive a health insurance premium remission as defined under the ASE/GSR collective bargaining agreement.
- I have a child dependent(s), as defined by UC SHIP plan regulations. Regulations are outlined at <https://myucship.org/>.
- I will provide a receipt of the payment for enrollment for my child dependent(s) in UC SHIP to my department administrator or designated campus office within ten (10) days of enrollment or as specified in local procedures.
- My income exceeds the Medi-Cal eligibility threshold for my family size. Information about Medi-Cal eligibility can be found here:
<https://www.dhcs.ca.gov/Medi-Cal/Pages/qualify.aspx>

If you have a spouse, please check the following section:

- I have a spouse and the combination of our income does not exceed twice the designated Medi-Cal eligibility threshold. Information about Medi-Cal eligibility can be found here:
<https://www.dhcs.ca.gov/Medi-Cal/Pages/qualify.aspx>
- I certify that the information provided above is a true and accurate reflection of my eligibility status for the quarter/semester in which I am seeking a child dependent insurance premium payment.
- I have completed and executed this form to the best of my knowledge and I have carefully reviewed UC SHIP plan regulations to verify the eligibility of the child dependent(s) and the Medi-Cal eligibility thresholds from the California Department of Health Care Services to verify my eligibility.
- I understand that if I do not enroll a dependent on the UC SHIP plan after submitting this Form, or if I try to enroll but am not eligible for enrollment in UC SHIP, and a dependent premium remission/reimbursement payment has been made to me, I shall reimburse the University for the remission/reimbursement payment.
- I understand that falsifying information on this Form regarding my eligibility for the dependent remission/reimbursement may be subject to discipline, up to and including dismissal.

First and Last Name: _____

Date: _____

Signature: _____