

Enrollment Benefits Worksheet - Please return to Benefits Services (BH 353)

Employee ID# _____ Employee Name: _____ SS# _____
 Department: _____ Classification/Work Title: _____ Email: _____
 Work Phone: _____ Home Phone: _____
 Marital Status: Married Single Domestic Partnership Spouse/DP SS# _____
 Mailing Address: _____
 Residence Address (If different): _____

Are you transferring from another campus or CalPERS/State Agency? Yes No Campus _____

Is your spouse currently employed by CSU? Yes No Name _____

Type of Transaction- Check all that apply:

- New Enrollment-Eligible for benefits but not currently enrolled in a plan
- Enroll in Flexcash Program: medical (\$128.00) dental (\$12.00)
(Complete flexcash enrollment form and attach proof of other non-CSU coverage)
- Enroll in Health Care Reimbursement **(Must complete HCRA enrollment form)**
- Enroll in Dependent Care Reimbursement **(Must complete DCRA enrollment form)**
- Change Plan-currently enrolled in a plan & wish to change
- Add Eligible Dependent(s) ***see back of worksheet for additional supporting document(s) required**
- Add Domestic Partner ***see back of worksheet for additional supporting document(s) required**
- Delete Dependent(s) from Plan
- Cancel Health Plan Coverage/Flex Cash

If an event has occurred that affects your insurance (such as a marriage, domestic partnership, divorce, birth, or death) **please specify below and indicate the date the event occurred.**

Event: _____ Date: _____

Medical Insurance Plans - Check plan selected:

PERS Care (PPO) Kaiser (HMO) Blue Shield (HMO)
 PERS Choice (PPO) Kaiser (outside of CA) Blue Shield Net Value (HMO)
 PERS Select (PPO) PORAC Blue Shield PCP Name and Prov # _____

Dental Insurance Plans - Check plan selected:

Delta Dental DeltaCare USA:(Specify provider Name & Facility#) _____

List each person to be enrolled in/deleted from Health and/or Dental and/or Vision plans including self.

No#	Relationship	Name (last, first, m.i.)	Date of Birth	Medical	Dental	Vision	Social Security Number
1	Self						
2							
3							
4							
5							

If you need to list additional dependents, please list them on the back side of this worksheet.

Please initial each statement & sign below.

_____ I certify that the names of all dependents listed above are eligible dependents as defined by CalPERS stated on the back of this worksheet.
 _____ I understand that supporting documents are required for each of my dependents within two weeks of the date I sign this worksheet.
 _____ I understand that my effective date is based on the date the official enrollment documents are signed & received by Benefits Services.

Employee's Signature: _____ **Date Signed:** _____

Benefits USE ONLY: Date Received in BS: _____ ACES Transmission #: _____ Initial COBRA/HIPAA: _____
 Supporting Docs Received: Marriage Cert. & Affidavit _____ Declaration of DP _____ Birth/Adoption Cert. _____
 Affidavit of Economic Dependent _____ Proof of other non-CSU Coverage _____ Divorce Decree _____

CalPERS guidelines for enrolling family members are as follows:

Your spouse or domestic partner can be added to your health plan if done within 60 days after the date of your marriage or registration of your domestic partnership. **A copy of your marriage certificate or Declaration of Domestic Partnership and your spouse's or domestic partner's Social Security number are required.** Former spouses and former domestic partners are not eligible.

Effective January 1, 2011, your child/children, are eligible for health coverage up to age 26. They are eligible even if they are married, do not live with you, or are not students. Please note that the dependent's spouse, or registered domestic partner, or children (unless the child is certifiably an economic dependent of the employee as specified below) are not eligible for coverage. Eligible children are defined as natural, adopted, step or domestic partner's children under age 26. **A birth certificate or adoption papers and Social Security number are required.**

A child over age 26, and is incapable of self support due to a mental or physical condition that existed prior to age 23, may be included when you first enroll. A Questionnaire for the **CalPERS Disabled Dependent Benefit Form (HBD-98)** and **Medical Report for the CalPERS Disabled Dependent Benefit Form (HBD-34)** must be approved by CalPERS prior to enrollment and must be updated upon request.

Another person's child under age 26 may be eligible for coverage if you have been granted custody or joint custody by a court or the child resides with you. An **Affidavit of Eligibility of Economically-Dependent Children Form (HBD-35)** must be filed prior to enrollment and must be updated upon request.

You can add the following family members either at the time of enrollment or at a later date:

- A spouse or registered domestic partner not living in your home
- Children age 18 or older
- Eligible children who are not in your custody
- Dependents in the military, when they return to civilian life

Split Enrollments

Members who are married or in a registered domestic partnership who both work, or works, for agencies in the CalPERS Health Program can enroll separately. If you and your spouse or domestic partner enrolls separately, you must enroll all eligible family members, regardless of the relationship, under only one of you. Dependents cannot be split between parents. For example, if a CalPERS member with children marries or registers a domestic partnership with another CalPERS member with children and each member has their own enrollment in the CalPERS Health Program, all children must be enrolled under one parent. The effective date of coverage will be the first of the month following the date of marriage or domestic partnership registration. If split enrollments are discovered, they will be retroactively corrected. You will be responsible for all costs incurred from the date the split enrollment began.

Dual Coverage

You cannot be enrolled in a CalPERS health plan as a member and a dependent or as a dependent on two enrollments. This is called dual coverage and it is against the law. When dual coverage is discovered the coverage will be retroactively canceled. You may have to pay for all costs incurred from the date the dual coverage began.

List Additional Dependents Below:

No#	Relationship	Name (last, first, m.i.)	Date of Birth	Medical	Dental	Vision	Social Security Number
6							
7							
8							
9							
10							