

Benefits Enrollment Worksheet - Please return to Benefits Services in Brotman Hall 353

Employee ID# _____ Employee Name: _____ SS# _____
 Campus Dept. _____ Classification/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

Type of Transaction- Check all that apply:

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

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 (HMO 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	add/delete
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. or 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.

Your children, adopted children, or stepchildren must be under age 23 and never married - regardless of whether or not they are living with you. **A birth certificate, adoption papers or other supporting documents are required.**

A child over age 23, who has never married 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 23 who has never married 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

List Additional Dependents Below:

No#	Relationship	Name (last, first, m.i.)	Date of Birth	Medical	Dental	Vision	<i>add/delete</i>
6							
7							
8							
9							
10							

INSTRUCTIONS – DECLARATION OF HEALTH COVERAGE (HB-12A)

Please contact your Health Benefits Officer if you have any questions regarding the HB12A.

Employee Information	Complete with the appropriate employee information.
Part A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
Part B-1:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage
Part B-2:	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
Part C-1:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
Part C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

Special rules for retirement and death:

Consider these points as you decide whether to enroll, decline, or cancel enrollment for yourself or dependents:

- ◆ If you are not enrolled in a CalPERS-sponsored health plan on the date you separate employment, you will not be eligible for health benefits into retirement.
- ◆ If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- ◆ If you die and your eligible family members are not enrolled on your CalPERS-sponsored health plan at that time, they will not be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.