CSUDH | HUMAN RESOURCES MANAGEMENT

Clear Form

Benefit Enrollment/Change Worksheet

This form can be submitted to the Benefits Office via the **Benefits Services Secure Dropbox** or in Welch Hall 340. If you prefer not to include SSNs, you must call (310) 243-3771 and speak to a staff member to provide this information.

This worksheet shall be used to initiate enrollment or make changes to your CSU benefits. This form must be received by the Benefits Office within 60 days of your appointment date or qualifying permitting event for timely enrollment. You have the option to voluntarily decline health and dental benefits offered by the CSU. If you do not select medical coverage (or FlexCash) within 60 days.

A Personal Information

Employee Legal Name (First, M, Last):	Employee ID #:
Mailing Address:	Daytime Phone #:
If mailing is P.O. Box, please provide physical address:	
Marital Status: ☐ Single ☐ Married – Date of Marriage _____ ☐ Domestic Partner – Date of D.P. _____	

B Type of Transaction

☐ New Enrollment	Date of Event: _____
☐ Add Spouse/Dependents ☐ Delete Spouse/Dependents	Reason for Change:
☐ Cancel Plan Coverage – Reason for Change:	
☐ Annual Open Enrollment – Specify Changes Requested:	
☐ Return from Unpaid Leave – Date of Return: _____ Proceed to section F (Previous plans will be reinstated)	

C Medical Plan Selection *Check plan you want to enroll in:*

PPO Plans: ☐ PERS Gold ☐ PERS Platinum ☐ PORAC - Unit 8 Only

HMO Plans: ☐ Anthem Cross Select ☐ Anthem Blue Cross ☐ Blue Shield Access+ ☐ Blue Shield Trio ☐ Health Salud Y Mas ☐ United HealthCare Alliance ☐ United HealthCare Harmony ☐ Kaiser Permanente

D Dental Plan Selection *Check plan you want to enroll in:*

☐ Delta Dental (PPO) ☐ DeltaCare USA (HMO)

FLEXCASH PLAN

☐ In lieu of health and/or dental coverage, I elect to enroll in FlexCash Health or Dental. *PLEASE COMPLETE BOX G ON REVERSE*

☐ I wish to cancel FlexCash Coverage

E List each dependent to be enrolled, added/deleted from plan(s) *See page 2 for required documents:*

Family Relationship	Legal Name (First, M, Last)	DOB (mm/dd/yyyy)	Social Security Number*	Health Add	Health Delete	Dental Add	Dental Delete	Vision Basic	Vision Premier
SELF				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

F Employee Certification *Please read and sign below:*

- I elect to enroll in, change, and/or cancel the benefit plan(s) as indicated above
- I certify that all dependents enrolled above are eligible family members and are not enrolled in another CalPERS health plan or CSU dental plan.
- I understand that I may only make plan changes or add/delete eligible dependents during the annual open enrollment period or after submitting supporting documentation of a qualifying event.
- I understand that the effective date of benefits depends on many factors; including my first day of employment, the date I submit enrollment documents, my pay plan, and the pay period.
- I understand that I am responsible for paying benefit deductions that may be owed due to enrollment or changes in benefits coverage.
- I understand the deductions will be taken out on my pay warrant automatically when the account receivable is established.

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

HR Office Use only:

Supporting Documents ☐ Address Checked ☐ PS Entry ☐ PIMS deductions ☐

Welcome Letter ☐ COBRA/HIPAA ☐ Audit CalPERS ☐ ACA Codes ☐ Eff. Date _____

G FlexCash Selection *Check Plan Selected:*

In lieu of health and/or dental coverage, I wish to enroll in:

☐ FlexCash Health ($128/mo.) ☐ FlexCash Dental ($12/mo.)

If other coverage is through your spouse or domestic partner, please provide their Social Security Number: _____

I certify that I am covered by another qualifying group health plan that conforms to the Affordable Care Act's (ACA's) minimum value standards. I certify that I will maintain coverage in a qualifying group health plan on an ongoing basis and I agree to notify my campus Benefits Officer within 60 days if I lose coverage under the medical and/or dental insurance plan(s). I understand that an individual health insurance policy (for example, Covered California or another insurance marketplace) and coverage under Tricare, Medicare, and Medi-Cal are not qualifying group health plan coverage for purposes of the FlexCash Benefit Program.

I must provide proof of alternate non-CSU group coverage with the benefits worksheet.

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

Enrollment Type	Required Copies of Supporting Documentation & Information
Active employee – **new** enrollment	N/A – If adding dependents see required documents below
Enroll or adding a **spouse**	Marriage Certificate (https://www.cdph.ca.gov/Programs/CHSI/Pages/Vital-Records-Obtaining-Certified-Copies-of-Marriage-Records.aspx)
Enroll or adding a **registered domestic partner**	Declaration of Domestic Partnership (from the California Secretary of State's Office) https://www.sos.ca.gov/registries/domestic-partners-registry/
Enroll or adding/deleting a **Dependent**	Qualifying reason for add/delete To Add: Birth Certificate, (https://www.cdph.ca.gov/Programs/CEH/Pages/CLPR.aspx)
Enroll or adding a dependent who is in a **parent-child relationship**	Employer and/or CalPERS reserves the right to request any supporting documentation Affidavit of Parent-Child Relationship (https://www.calpers.ca.gov/docs/forms-publications/affidavit-parent-child-form.pdf)
Deleting a spouse due to divorce	Divorce Decree (Only available from the Superior Court in the county where the divorce was filed)
Deleting a registered domestic partner due to termination of partnership	Termination of Domestic Partnership submitted to the California Secretary of State's Office (https://www.sos.ca.gov/registries/domestic-partners-registry/forms-fees/)
Enrolling self or dependents due to **loss of other coverage**	*BirthCertificate*, (child) http://www.cdph.ca.gov/certlic/birthdeathmar/pages/default.aspx *MarriageCertificate*, (spouse) https://www.cdph.ca.gov/Programs/CHSI/Pages/Vital-Records-Obtaining-Certified-Copies-of-Marriage-Records.aspx *Declaration of Domestic Partnership* (domestic partner) https://www.sos.ca.gov/registries/domestic-partners-registry Need proof of coverage loss (all)
Death of employee or dependent	Need written notification of date of death

***SOCIAL SECURITY NUMBERS REQUIRED FOR ALL SUBSCRIBERS AND DEPENDENTS**

With the passage of the Health Care Reform Act in March 2010, CalPERS is required to report the Social Security members of all subscribers and their dependents. Dependents include the spouse or domestic partner and/or children. We do not need to view or have copies of Social Security cards but are required to have the Social Security number information on file for all health/dental/vision enrolled dependents. The CalPERS health program and CSU Dental plan uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees
3. Billing of contracting agencies for employee and employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among health plans
6. Resolution of member complaints, grievances and appeals with health plans

More detailed information can be found in the Benefits Enrollment Instructions at www.calpers.ca.gov or by calling CalPERS at (888-225-7377).

Submit the Benefits Enrollment Form to the Benefits Services Dropbox or to WH 340

CALPERS GUIDELINES FOR ENROLLING FAMILY MEMBERS ARE AS FOLLOWS:

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. Eligible children are defined as natural, adopted, step or domestic partner's children under age 26. If your dependent is married you may not enroll their spouse or children (unless the child is an economic dependent of the employee). **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 26, may be included when you first enroll. A questionnaire for the **CalPERS Disabled Dependent Benefit Form (HBD-98) and Medical Report of 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. **Birth Certificate, Social Security Number and Affidavit of Eligibility of Economically Dependent Children Form (HBD-35)** must be filed prior to enrollment and must be updated upon request.

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 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 must pay for all costs incurred from the date the dual coverage began.

IMPORTANT: It is your responsibility to notify the Benefits Services department when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, changes of address, marriage, divorce, legal separation and death. Failure to notify the Benefits Office may result in adverse consequences.

ACKNOWLEDGEMENT & MISSED PREMUIM ACCOUNTS RECEIVABLE AGREEMENT

The CSU Benefits Summary is intended to provide an overview of the benefits generally available to CSU employees. This is a summary of benefits and should not be construed as a substitute for the master contracts or official plan documents. More detailed information about each of our benefit plans can be found in the individual plan summaries and official plan documents. If you need copies of these materials, please visit individual health plan's website.

Carrier premium and coverage information may change during your employment at CSUDH as a result of collective bargaining, changes in legislation, or CalPERS vendor contract negotiations. You will receive advance written notification from the carrier, CSU, Benefits Office of any such changes affecting your benefits.

If you have recently moved, please make sure your most recent address is updated by completing the **Employee Action Request Form (EAR)** to ensure you receive important benefits and tax information in a timely manner.

Please note the following effective dates:

Medical/Dental: Coverage begins on the first day of the month following receipt of the enrollment forms and required documents to Benefits Office in WH 340, within 60-days from date of eligibility or hire to avoid a 90 day waiting period.*

Flexcash: The effective date is the first day of the second month following receipt of the enrollment forms and supporting documents to Benefits Office in WH 340, within 60-days from date of eligibility or hire.

Vision: The CSU provides two vision plans for all eligible employees and their dependents. Employees who are eligible for benefits will be automatically enrolled in the basic plan effective the 1st of the month after their hire date for staff, and beginning of eligible semester for Faculty. Employees have 60 days from eligibility or hire date to enroll in the optional premier plan for a fee.

** Note for Faculty: For Fall semester enrollees, medical, dental, and vision coverage is effective Oct. 1st for enrollment forms submitted by Sept. 30th. Forms submitted in October (within the 60-day limit) will be effective Nov. 1st for medical, dental, and vision. For Spring semester enrollees, medical, dental, and vision coverage is effective March 1st for enrollment forms submitted by Feb. 28th. Forms submitted in March (within the 60-day limit) will be effective April 1st for medical, dental, and vision.*