



CSU, CHICO BENEFITS WORKSHEET

EMPLOYEE'S NAME (FIRST, MIDDLE, LAST)	SSN
ADDRESS (NUMBER & STREET, CITY, STATE & ZIP)	Phone # you can be reached
Have you ever had health benefits through the California State University? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> Domestic Partner (DP)	SPOUSE / DP SSN:

HEALTH INSURANCE PLAN

TAX ADVANTAGE PREMIUM PLAN (TAPP) allows you to pay required health plan premiums from your salary on a pre-tax basis.
 I elect NOT to participate in the Tax Advantage Premium Plan.

FLEXCASH OPTION (Cash Payment in exchange for waiving CSU medical and/or dental coverage)
PROOF OF ALTERNATE NON-CSU COVERAGE REQUIRED

I elect to enroll in FlexCash for: Health only (\$128/mo) Dental only (\$12/mo) Health & Dental (\$140/mo)

DENTAL INSURANCE PLANS -- please select plan by checking the appropriate box

<input type="checkbox"/> DELTA DENTAL (PPO) <input type="checkbox"/> PMI/DELTA CARE (HMO)	PLEASE INDICATE DENTIST (if you selected PMI/DeltaCare)
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LIST ALL PERSONS TO BE ENROLLED / DELETED IN BENEFIT PLANS (INCLUDING YOURSELF)

For the addition of eligible dependents in the following categories, you must provide additional documentation (in parenthesis): spouse (copy of marriage certificate or affidavit), domestic partner (declaration of domestic partnership, statement of financial liability, other forms as appropriate) or economically dependent child (affidavit or court order). For the deletion of dependents such as spouse due to divorce, you must provide a copy of the divorce decree or termination of domestic partnership (filed with California). If you are enrolling in health/dental benefits outside of open enrollment and you are currently on the Flexcash plan, you must provide evidence of termination of other non-CalPERS health coverage.

If you have selected an HMO, indicate a Primary Care Physician (PCP). Each dependent may have a different PCP. If you do not choose a PCP one may be assigned by your health care provider.

RELATIONSHIP	NAME (FIRST, LAST)	HEALTH	DENTAL	VISION	DOB	Gender M/F	ACTION
SELF		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Add <input type="checkbox"/> Delete
Primary Care Physician		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Add <input type="checkbox"/> Delete
Primary Care Physician		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Add <input type="checkbox"/> Delete
Primary Care Physician		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Add <input type="checkbox"/> Delete
Primary Care Physician		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Add <input type="checkbox"/> Delete

If current employee, reason for change:

Date of change:

EMPLOYEE SIGNATURE: _____ **DATE:** _____

**Completion of this form does not signify official enrollment.

FOR BENEFITS USE ONLY:

Employee ID #: _____

Empl Rcd Nbr # _____

CBID: _____

Newly Eligible

Open Enrollment

Late Enrollment

	Health	Dental	Vision			Life	Long Term Disability
Coverage Begin Date:							
Deduct Begin Date:							
Election Date:							
Benefit Plan:							
Coverage Code:							
Permitting Event Code:							
Permitting Event Date:							
Eligibility Zip (Work):							

Permitting Event
Comments: _____

**BENEFITS OFFICE
SIGNATURE:** _____

DATE: _____

EMPLOYEE NAME _____

POSITION NUMBER (PIMS) _____

SSN _____

DATE OF ACES TRANSMITTAL _____

FLEXCASH/ DENTAL SENT TO SCO _____

VISION/LIFE/LTD FTP PROCESS _____

INITIAL COBRA NOTICE SENT _____

GRP LIFE INS & BEN DESIG. _____

GROUP LTD POLICY _____

PMI ORTHO INFO _____

HIPAA NOTICE _____

EOC DENTAL PLAN _____

INITIAL ENROLL. INFO. _____

OTHER _____