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CALIFORNIA STATE UNIVERSITY, CHICO

HUMAN RESOURCES SERVICE CENTER
BENEFITS

400 W. 1ST STREET
KENDALL HALL ROOM 118
CHICO, CA 95929-0010
530-898-5436
FAX: 530-898-4817

Benefit Enrollment/ Change Worksheet

You have the option to voluntarily decline benefits offered by the CSU. If you do not select medical coverage (or FlexCash) within 60 days from your date of hire, then you are agreeing, by default, to decline the offer of medical coverage.

A - Personal Information

Employee Legal Name: First and Last Name	**Employee ID #:**
Mailing Address:	**Daytime Phone #:**
If mailing is P.O. Box provide physical address:	

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner (DP)

B - Type of Transaction - *Select only one*

☐ **New** Enrollment

Are you currently enrolled in a CalPERS health plan? ☐ No ☐ Yes If yes, please list Employer: _____

☐ **I voluntarily decline** enrollment into the CalPERS Health Program for myself and my dependents. Proceed to section G

☐ **Add** Spouse/Dependent(s) - Reason for change:

☐ **Delete** Spouse/Dependent(s) - 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 G (Previous benefit plans will be reinstated)

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

PPO Plans: ☐ PERS Care ☐ PERS Select California ☐ PERS Choice

HMO Plan: ☐ Blue Shield Access + California

Note: Additional plans (based on your residence's zip code) may be available if residing out of area. If selecting an out of area plan, please list name here: _____

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

Delta Dental (PPO): ☐ DeltaCare USA (HMO): ☐ Specify provider (HMO only): _____

E - FlexCash Plan

☐ In lieu of health and/or dental coverage, I elect to enroll in FlexCash Health or Dental.

PLEASE COMPLETE BOX H ON REVERSE

☐ I wish to cancel FlexCash coverage.

F - List each person to be enrolled, added and/or deleted from plan(s) - *See page 2 for required documents:*

	Family Relationship	Legal Name First and Last name	DOB mm/dd/yy	Social Security Number*	Gender M/F	Health Add	Health Delete	Dental Add	Dental Delete	Vision Add	Vision Delete
1	**SELF**					☐	☐	☐	☐	☐	☐
2						☐	☐	☐	☐	☐	☐
3						☐	☐	☐	☐	☐	☐
4						☐	☐	☐	☐	☐	☐

G - Employee Certification - *Please read and sign below:*

- I voluntarily decline, 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 life 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.

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

Office Use only: Supporting Documents ☐ Address checked ☐ Keyed in PIMS ☐ PERS ID entered ☐ ACA Codes ☐
Welcome email ☐ COBRA/HIPAA ☐ Audit PIMS ☐ Audit CalPERS ☐ DOH _____

H - 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/Marriage-License-Information.aspx
Enroll or adding a **registered domestic partner**	*Declaration of Domestic Partnership* from the California Secretary of State's Office www.sos.ca.gov/registries/domestic-partners-registry/
Enroll or adding/deleting a **dependent**	Qualifying reason for add/delete *Birth Certificate*, https://www.cdph.ca.gov/Programs/CHSI/Pages/Birth,-Death,-Fetal-Death,-Still-Birth--Marriage-Certificates.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* (HBD-40) 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/
Enroll **Disabled child** over age 26	*Member Questionnaire for the CalPERS Disabled Dependent Benefit* form (HBD-98) https://www.calpers.ca.gov/docs/forms-publications/questionnaire-disabled-dependent-form.pdf *Medical Report for the CalPERS Disabled Dependent Benefit* form (HBD-34) https://www.calpers.ca.gov/docs/forms-publications/medical-report-dependent-form.pdf *Birth Certificate*, https://www.cdph.ca.gov/Programs/CHSI/Pages/Birth,-Death,-Fetal-Death,-Still-Birth--Marriage-Certificates.aspx
Enrolling self or dependents due to **loss of other coverage**	*Birth Certificate*, https://www.cdph.ca.gov/Programs/CHSI/Pages/Birth,-Death,-Fetal-Death,-Still-Birth--Marriage-Certificates.aspx *Marriage Certificate*, https://www.cdph.ca.gov/Programs/CHSI/Pages/Marriage-License-Information.aspx Declaration of Domestic Partnership (domestic partner) https://www.sos.ca.gov/dpregistry/ Need proof of coverage loss (all)
Death of employee, retiree, or family member	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.

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