Clear Form Print Form

California State University Chico
Human Resources Service Center
BENEFITS

400 W. 1ST STREET
KENDALL HALL ROOM 213
CHICO, CA 95929-0010
530-898-5436
FAX: 530-898-4364

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 medial 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 Gold (California only) ☐ PERS Platinum
HMO Plan: ☐ Blue Shield Access + HMO (California only)
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 and/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/yyyy	**Social Security Number**	**Gender** Male/Female Nonbinary	**Health** Add	Delete	**Dental** Add	Delete	**Vision** Add	Delete
1	SELF					☐	☐	☐	☐	☐	☐
2						☐	☐	☐	☐	☐	☐
3						☐	☐	☐	☐	☐	☐
4						☐	☐	☐	☐	☐	☐
5						☐	☐	☐	☐	☐	☐
6						☐	☐	☐	☐	☐	☐

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

- I voluntarily decline, elect to enroll, in change, and or cancel the benefit plans(s) as indicated above.
- I certify all dependents enrolled above are eligible family members and are not enroll in another CalPERS health plan or CSU dental plan.
- I understand that I may only make plan changes or add/delete 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 ☐ Welcome email ☐ Address Checked ☐ COBRA/HIPPA ☐ Keyed in PIMS ☐ Audit PMS ☐ PERS ID entered ☐ Audit CalPERS ☐ ACA Codes ☐ DOH _____

H - Flex Cash 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 Birth Certificate, https://www.cdph.ca.gov/Programs/CHSI/Pages/Vital-Records-Obtaining-Certified-Copies-of-Birth-Records.aspx
Enroll or adding a dependent who is in a **parent-child relationship**	Employer and/or CalPERS reserves the right to request any supporting documenation 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://dp.cdn.sos.ca.gov/forms/sf-dp2.pdf
Enroll **Disabled child** over age 26	Disabled Dependent Member Questionnaire and Medical Report Birth Certificate
Enrolling self or dependents due to **loss of other coverage**	Birth Certificate, Marriage Certificate, Declaration of Domestic Partnership 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 Benefit Enrollment instructions, at www.calpers.ca.gov or by calling CalPERS at 888 CalPERS (or 888-225-7377).