Open Enrollment Benefits Worksheet - *Please return to Benefits Services (BH 353) by Oct. 5, 2012*

Employee ID# _____ Employee Name: _____ SS# _____

Department:_____ Classification/Work 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 Name _____

Type of Transaction- Check all that apply:

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

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: Open Enrollment Date: 9/10/2012

Medical Insurance Plans - Check plan selected:

_____PERS Care (PPO) _____Kaiser (HMO) _____Blue Shield (HMO)

_____PERS Choice (PPO) _____Kaiser (outside of CA) _____Blue Shield Net Value (HMO)

_____PERS Select (PPO) _____PORAC

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	*Social Security Number*
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 and supporting documentation has been provided.*

_____*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. & 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.

Effective January 1, 2011, your child/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 a economic dependant 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 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 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.

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
- Eligible children who are not in your custody
- Dependents in the military, when they return to civilian life

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 a 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 may have to pay for all costs incurred from the date the dual coverage began.

List Additional Dependents Below:

No#	Relationship	Name (last, first, m.i.)	Date of Birth	Medical	Dental	Vision	***Social Security Number***
6							
7							
8							
9							
10							