2017 Open Enrollment (9/11 – 10/6)

California State University, San Bernardino

Changes are effective January 1, 2018

DEADLINE: This form must be received in Human Resources (SH-110) **before 4:45 pm Friday, October 6, 2017.**

Please provide all requested information below and bring required documentation. This is not an official document. You will be notified to **return to Human Resources before Wednesday, October 25, 2017.** Official health and HCRA/DCRA forms **must be signed by the employee** or we cannot process your request.

Transaction	Description	Medical	Dental	Vision	HCRA/DCRA
New	First time enrollment (currently not enrolled in any plan)	☐	☐	N/A	☐
Change	From current plan to a different one	☐	☐	N/A	N/A
Add	Eligible dependents currently not enrolled	☐	☐	☐	N/A
Delete	Dependents currently enrolled	☐	☐	☐	N/A
Cancel	Dis-enroll from current coverage	☐	☐	N/A	N/A
Flexcash	Enroll in or cancel to enroll in a plan	☐	☐	N/A	N/A

Employee Information:

First Name	M.I.	Last Name	Social Security Number (last 4)	
Street Address	City		State	Zip
Sex ☐ Female ☐ Male	Relationship ☐ Single ☐ Married ☐ Domestic Ptr	Home Phone	Cell Phone	Campus Phone X7
Campus Department	Email Address	My Coyote #		Bargaining Unit

Only list dependents to add or remove

HR website: https://www.csusb.edu/human-resources

Name (Use reverse side of sheet, if needed)	Date of Birth (mm/dd/yy)	Social Security Number (Required)	Relationship/Gender (Spouse, Dom. Partner, Son, Daughter, Male/Female etc.)	Medical		Dental		Vision	
				Add	Del	Add	Del	Add	Del
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

Required documents *to ADD or REMOVE dependents*:

***Marriage Certificate** – Required to add your Spouse to any plan.

***Social Security Number** – Required for all dependents. Please bring a card for each dependent.

***Proof of Residency** – Required to add a Spouse (Example: Current bill/statement/tax return showing spouse's name and your home address).

***Birth Certificate** - Required to add child(ren) under the age of 26 to any plan.

***Declaration of Domestic Partnership** – Required to add your Domestic Partner to any plan.

***Notice of Entry of Judgment** – Required to remove Ex-Spouse (Divorce)

***Notice of Termination of Domestic Partnership** – Required to remove Ex-Domestic Partner

***Medical/Dental cards from other coverage** – To show proof of other employer sponsored coverage

Bring the **ORIGINAL documents*. Our office will make a copy of the document(s) for our file. *Thank you!*

TURN OVER TO MAKE PLAN SELECTIONS ➔

FLEXIBLE SPENDING ACCOUNTS (HCRA/DCRA) – Must re-enroll every year to continue.	
Health Care Reimbursement Account **AND/OR** Dependent Care Reimbursement Account ***Note:*** Minimum deduction $20 per month	☐ HCRA $_____ **monthly** amount ($2,600 yr max) ☐ DCRA $_____ **monthly** amount ($5,000 yr max)

MEDICAL PLAN SELECTION (check one) Current plan continues unless you request a change.	
HMO Plans **	**PPO Plans**
Make sure your Primary Care Physician (PCP) accepts the plan	
☐ Anthem SELECT ☐ Anthem Traditional ☐ Blue Shield Access+ ☐ Health Net SALUD Y MAS ☐ Health Net Smartcare ☐ Kaiser ☐ Sharp **San Diego only** ☐ United Healthcare	☐ PERS CARE 90/10 plan ☐ PERS Choice 80/20 plan ☐ PERS Select 80/20 plan **In CA only** ☐ PORAC **Dues Paying POLICE (R08) only**

**** HMO plans require a Primary Care Physician (PCP). Make sure your PCP accepts the plan you select. Instructions will be given after you sign the final documents how to designate your PCP through your plan.**

DENTAL PLAN SELECTION (check one) Current plan continues unless you request a change.	
☐ DeltaCare USA (DMO)	☐ Delta Dental of CA (PPO)

If selecting DeltaCare USA, you ***must*** specify a participating dental office:

DeltaCare USA Provider	Provider Office #	City

FlexCash Enrollment (List Spouse's SSN in Dependent Section)	List Other ***Employer*** Covered Plan Company Name (Ex., Aetna, Blue Cross, etc)	List Other ***Employer*** Coverage Group Number
In lieu of Medical coverage		
In lieu of Dental coverage		

Employee Signature > > >	X_____ Date:

THIS IS ONLY A WORKSHEET.

You will be notified by phone or email to return to HR once your OFFICIAL open enrollment form(s) are prepared and ready for your signature. Any health plan changes, HCRA or DCRA documents that aren't signed by *Wednesday, October 25, 2017* cannot be processed and changes will not take effect January 1, 2018.

Please use this area for additional information or comments: