CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

Benefits Enrollment Worksheet

The following information is required to complete any transaction(s) affecting medical, dental, vision, flexcash coverage and/or flexible spending accounts. Submit this completed worksheet and any required documents to HR Benefits in Sierra Hall 113.

I. EMPLOYEE INFORMATION

Employee Legal Name (First and Last Name)	Date of Birth	Gender ☐ M ☐ F	Social Security Number or Campus ID
Physical Address	Marital Status ☐ Single ☐ Married ☐ Domestic Partner		Preferred Contact ☐ E-mail ☐ Phone
Mailing Address (if different from physical address)	Date of Marriage/Domestic Partnership		Department

Are you transferring from a CalPERS/State Agency? ☐ NO ☐ YES If yes, please list the Agency: ______________________________

Are you currently working at another CalPERS/State Agency/Public Agency? ☐ NO ☐ YES If yes, please list the Agency: ______________________

Are you a CalPERS Retiree? ☐ NO ☐ YES (CalPERS Retirees are not eligible for benefits. Please contact HR Benefits for more information.)

☐ **New Enrollment** *(Proceed to Section III to continue)* **Date of Hire:**

☐ **Change of Enrollment** *(Proceed to Section II to continue)*

II. TRANSACTION INFORMATION

All transactions require supporting documents and cannot be processed without them. Please refer to the following page for required documents.

Addition Events	Date of Event	Deletion Events	Date of Event
☐ Birth of Child		☐ Death	
☐ Court Order		☐ Divorce*	
☐ Custody Change		☐ Domestic Partnership Termination*	
☐ Domestic Partnership		☐ Dependent Enrolling as State Employee	
☐ Economically Dependent Child		☐ Entering Military Service	
☐ Loss of Coverage		☐ Gained Non-CSU/Alternative Coverage	
☐ Marriage		☐ Loss of Economic Dependence	
		☐ Moved out of Household	

*Please list former spouse's/Domestic Partner's address:

Flexible Spending Accounts

☐ Dependent Care Reimbursement Account – (DCRA) $_______________monthly amount ($20 minimum; $416.66 maximum)

☐ Health Care Reimbursement Account - (HCRA) $_________________monthly amount ($20 minimum; $220.83 maximum)

III. MEDICAL PLANS

HMO: ☐ Anthem Select ☐ Anthem Traditional ☐ Blue Shield Access+ ☐ HealthNet Salud Y Mas ☐ HealthNet Smartcare ☐ Kaiser ☐ Sharp (San Diego Only) ☐ United HealthCare

PPO: ☐ PERS Care ☐ PERS Choice ☐ PERS Select ☐ PORAC (R08 only)

IV. DENTAL PLANS

☐ DeltaCare USA DMO (Provider Name: _________________________________ Office/Provider ID: ______________________) ☐ Delta Dental PPO

V. FLEXCASH ENROLLMENT INFORMATION

Per IRS regulations, alternate medical coverage must be a group coverage. Covered California and other Insurance Marketplaces such as Tricare, Medicare, or Medi-Cal are individual plans that are not eligible to receive Medical FlexCash. You must provide proof of alternate group coverage that is Non-CalPERS (i.e. medical ID card).

Enroll	Cancel	Plan	Employer Name Offering Coverage	Provider Group Name	Provider Group #	Spouse's/Domestic Partner's SSN
☐	☐	Medical				
☐	☐	Dental				

__________ (Initials) I have reviewed the FlexCash brochure describing CSU's optional FlexCash Plan. I understand that under IRS Code regulations, my elections are irrevocable during this plan year unless I have an allowable "family status change event" and/or other permitting event(s) as described in IRS regulations and/or the FlexCash brochure.

VI. DEPENDENT INFORMATION

Is your Spouse/Domestic Partner currently enrolled in a medical/dental plan through a CalPERS/State Agency? ☐ NO ☐ YES

If yes, please list the Agency your Spouse/Domestic Partner is working for: ____________________

If yes, are you/your dependents currently enrolled on your Spouse/Domestic Partner's plan? ☐ NO ☐ YES

Are you/your dependent(s) being deleted from this coverage? If yes, list the effective date: ____________________

Name	Date of Birth	Relationship	SSN	Gender	Medical		Dental		Vision	
					Add	Del	Add	Del	Add	Del
				☐M ☐ F	☐	☐	☐	☐	☐	☐
				☐M ☐ F	☐	☐	☐	☐	☐	☐
				☐M ☐ F	☐	☐	☐	☐	☐	☐
				☐M ☐ F	☐	☐	☐	☐	☐	☐
				☐M ☐ F	☐	☐	☐	☐	☐	☐
				☐M ☐ F	☐	☐	☐	☐	☐	☐

Dependent Supporting Documentation Required

Your dependents must meet the eligibility criteria set by CalPERS. Please refer to the CalPERS Health Program Guide for more details. **You must bring the required documents to HR Benefits in Sierra Hall 113. Our Office will make a copy of them for your file.**

Spouse or Domestic Partner (adding)	**Marriage Certificate/Declaration of Domestic Partnership** **Social Security Card** **Proof of Residency** (i.e. utility bill, front page of the most recent year income tax return showing the same address as employee).
Spouse or Domestic Partner (deleting)	**Divorce Decree/Termination of Domestic Partnership** **Death Certificate** **Evidence Of Gaining Alternate Coverage**
Children	**Birth Certificate(s)/Hospital Record (newborns)** or **Adoption Papers** **Social Security Card(s)**
Disabled Children Over Age 26	If you have a disabled child with a Social Security-approved disability, you must provide CalPERS with a copy of his or her Medicare card. In addition, you must submit a **Member Questionnaire for the CalPERS Disabled Dependent Benefit form**, and your doctor must complete a **Medical Report for the CalPERS Disabled Dependent form** for CalPERS approval. The documents must be approved by CalPERS prior to enrollment and must be updated upon request.
Parent-Child Relationship	**Affidavit of Parent-Child Relationship** **Birth Certificate** **Social Security Card** **Recent income tax return or court order naming employee/spouse as legal guardian, and/or daycare receipts/school records indicating residence at employees' mailing address**. Submit the Affidavit and tax return annually thereafter up to age 26. HR Benefits will approve/deny each affidavit.
Split Enrollments	When two active or retired members are married to each other or they are in a domestic partnership, each member can enroll separately. However, when these individuals enroll in a CalPERS health plan in their own right, one parent must carry all dependents on one health plan. Parents cannot split enrollment of dependents. CalPERS will retroactively cancel split enrollments. You may be responsible for all costs incurred from the date the split enrollment began.
Enrolling in Two CalPERS Health Plans	Dual CalPERS coverage occurs when you are enrolled in a CalPERS health plan as both a member and a dependent or as a dependent on two enrollments. **This duplication of coverage is against the law**. When dual CalPERS coverage is discovered, the enrollment that caused the dual coverage will be retroactively canceled. You may be responsible for all costs incurred from the date the dual coverage began. Members may enroll in both a CalPERS health plan and a health plan provided through another non-CalPERS employer. During Open Enrollment, it is your/your dependent's responsibility to submit an Open Enrollment transaction with the appropriate agency to request deletion from the other plan. We are not able to process the enrollment until the cancellation with the other plan has processed.

VII: ENROLLMENT

☐ **To enroll, carefully review the information in this section and check the box:**

I ELECT TO ENROLL in (or **MAKE CHANGES TO**) a CalPERS Health Program as indicated on the previous pages and agree to authorize deductions from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future. **I CERTIFY** that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. **I AGREE** to read the associated Evidence of Coverage (EOC) and any subsequent EOC's in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all of the terms and conditions of the EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any medical malpractice dispute regarding medical services rendered under this contract were unnecessary, unauthorized, improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law. There will not be a lawsuit or court process except as California Law provides for judicial review of arbitration proceedings. By entering into this agreement, the parties are giving up their constitutional right to have any dispute decided in a court of law before a jury and instead they are accepting the use of arbitration.

☐ **To decline, carefully review the information in this section and check the box:**

I DECLINE ENROLLMENT into a CalPERS Health Program for myself and/or my dependents.

I UNDERSTAND that if I choose to enroll later, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in a health benefits plan. Furthermore, if my dependents and/or I involuntarily lose other health/dental insurance coverage, I may request enrollment into either Program within 60 days from the date of loss of coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the following month following the 90-day wait period or the OE effective date.

____ _______________________

Employee Signature Date

____

Benefits Staff Signature

Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with statuses regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its function regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Service Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public law 93-579) requires that Federal, State and/or Local Government Agencies to disclose if the Social Security Number is mandatory, voluntary and which statutory or other authority the number is solicited by, and the purpose of such disclosure. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security Numbers for the coordination of Federal and State benefits.

The CalPERS Health Program and CSU Dental Plan uses Social Security Numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contributions for State employees
3. Billing of contracting agencies for employee and employer contributions
4. Reports to CalPERS and other State Agencies
5. Coordination of benefits among health plans
6. Resolution of member complaints, grievances and appeals with health plans

IMPORTANT: It is your responsibility to notify HR Benefits when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, changes of address, marriage, divorce, legal separation and death. Failure to notify HR Benefits may result in adverse consequences.