



## Benefits Enrollment / Change Form

**Legal Name:** \_\_\_\_\_ **Employee SS#:** \_\_\_\_\_  
First M.I. Last

**Address:** \_\_\_\_\_  
Number and Street City State Zip Code

Do you prefer to use your work address for benefits purposes? \_\_\_\_ Yes \_\_\_\_ No

Are you transferring from a CalPERS/State Agency? \_\_\_\_ Yes \_\_\_\_ No

If yes, which agency? \_\_\_\_\_

**Gender:**  Male  Female

**Daytime Phone Number:** \_\_\_\_\_ **Campus Phone Number:** \_\_\_\_\_

**Marital Status:**

- Single
- Married – Marriage Certificate or Affidavit of Marriage required
- Domestic Partnership – Declaration of Domestic Partnership from State of California is required

Is your spouse/domestic partner currently employed by a CSU? \_\_\_\_ Yes \_\_\_\_ No

**Check action(s) to be taken:**

- New Enrollment – Eligible for benefits but not currently enrolled  
*(You have 60 days from your date of hire/eligibility to enroll into benefits without a 90-day waiting period)*
- Enroll in FlexCash Program  
\_\_\_\_\_ Medical (\$128.00) \_\_\_\_\_ Dental (\$12.00)  
*(You can waive CSU medical/dental insurance and elect FlexCash if you have an eligible alternative insurance plan. Complete FlexCash enrollment form and provide proof of other non-CSU coverage)*
- Change Plan  
*(Complete Employee Action Request form to officially change address)*
- Add eligible dependents  
*(Include supporting documentation, such as marriage certificate, Declaration of Domestic Partnership, birth certificate for children, Affidavit of Eligibility for economically dependent child)*
- Delete Dependent(s)  
*(A copy of the final divorce decree is required in the case of a divorce)*
- Cancel Plan

Specify below if an event has occurred that affects your benefits eligibility *(such as marriage, domestic partnership, divorce, birth, or loss/gain of non-CSU benefits coverage)*.

Event: \_\_\_\_\_ Date of Event: \_\_\_\_\_

**HEALTH:** Check the medical plan of your choice:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> PERS Care PPO            | <input type="checkbox"/> PERS Choice PPO        | <input type="checkbox"/> PERS Select PPO |
| <input type="checkbox"/> Kaiser HMO               | <input type="checkbox"/> PORAC (Unit 8 only)    |  |
| <input type="checkbox"/> Blue Shield Access+ HMO* | <input type="checkbox"/> Blue Shield Net Value* |  |

\* For Blue Shield health insurance only, list Medical Provider's number in the space provided below. Medical Provider numbers can be obtained on Blue Shield's web site at [www.blueshieldca.com/calpers](http://www.blueshieldca.com/calpers).

**DENTAL:** Check the dental plan of your choice:

- |   |   |
|---|---|
| <input type="checkbox"/> Delta Dental PPO | <input type="checkbox"/> Delta Care USA*: _____<br>(Delta Care provider's name) |
|---|---|

**Eligible Members:** List the **legal** name(s), birth date(s), relationship(s), gender(s) and social security number(s) of all eligible members to be covered (including yourself). When adding or deleting a dependent(s), check Add or Delete in the space provided.\* All dependents listed, other than spouse or domestic partner, must be under the age of 26. You may not enroll your dependent if he or she is already covered by a CalPERS health plan or State of California dental plan.

Eligible Members	Legal Name	Birth Date	Relationship	Gender	Social Security Number	Dental Add / Delete	Medical Add / Delete	* Provider # for Blue Shield HMO and/or Delta Care only
_____	_____	_____	<b>SELF</b>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* Use an additional sheet if necessary.

**Initial each statement & sign below:**

- \_\_\_\_\_ I certify that the name(s) of all dependent(s) listed above are eligible as defined in the Public Employees' Medical and Hospital Care Act and they are not enrolled in another CalPERS medical plan or State of California dental plan.
- \_\_\_\_\_ I understand that supporting documents are required for each of my dependents within two weeks of the date I sign this worksheet.
- \_\_\_\_\_ I understand that the effective date of my benefits is based on the date the fully completed enrollment form and required supporting documents as indicated on the front of this form are signed and received by the Benefits Office.
- \_\_\_\_\_ I also authorize the SDSU Benefits Officer to sign my name on the Dental Plan Enrollment Authorization Form (STD 692) in order to expedite my dental enrollment. I understand that I will receive a copy of the signed dental enrollment document.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Human Resources Use Only:**

Benefits Representative's Received Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Verify enrollment against ACES: \_\_\_\_\_

Verify enrollment against SCO (includes medical, dental, vision, life insurance and LTD): \_\_\_\_\_

### **Guidelines for enrolling family members:**

- 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. (Review Enrolling Domestic Partners for specific enrollment requirements.) Former spouses and former domestic partners are not eligible.
- Your children, adopted children, or stepchildren must be under age 26 regardless of whether or not they are living with you. A copy of the child's birth certificate and his/her Social Security number are required.
- A child over age 26, who is incapable of self support due to a mental or physical condition that existed prior to age 23, may be included when you first enroll. A Questionnaire for 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. A copy of the child's birth certificate and his/her Social Security number are required.
- 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. An Affidavit of Parent - Child Relationship form (HBD-40) must be filed prior to enrollment and must be updated upon request. A copy of the child's birth certificate and his/her Social Security number are required.

You can add the following family members at the time of enrollment or at a later date (supporting documentation will be required):

- Spouse or registered domestic partner not living in your home. A copy of your marriage certificate or Declaration of Domestic Partnership and your spouse's or domestic partner's Social Security number are required.
- Children age 18 or older. A copy of the child's birth certificate and his/her Social Security number are required.
- Eligible children who are not in your custody. A copy of the child's birth certificate and his/her Social Security number are required.
- Dependents in the military, when they return to civilian life. A copy of your marriage certificate or Declaration of Domestic Partnership and your spouse's or domestic partner's Social Security number are required **AND/OR** a copy of the child's birth certificate or and his/her Social Security number are required.

### **Split Enrollments**

Members who are married or in a registered domestic partnership who both work, or worked, for agencies in the CalPERS Health Program can enroll separately. If you and your spouse or domestic partner enroll 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.

### **Family Status Changes — Adding or Deleting Dependents**

#### **Divorce or Termination of Domestic Partnership**

If you divorce or terminate a domestic partnership, your former spouse/domestic partner is no longer eligible to be enrolled in your health coverage, even if the court orders you to provide health coverage for them. The coverage terminates on the first day of the month in which the final decree of divorce or termination is granted. Former spouses may be eligible for coverage under a COBRA or an Individual Conversion Policy. You must submit a copy of your final divorce decree or Notice of Termination of Domestic Partnership form to your personnel office (if active) or CalPERS (if retired).

#### **Newborn or Newly Adopted Child**

You must enroll within 60 days from the date of birth; however, your newborn child is covered from the date of birth. Adopted children are covered beginning the date formal adoption takes effect. A copy of the child's birth certificate or and his/her Social Security number are required.

#### **Death of a Member**

In the event of a retired member's death, please report this information by contacting us at **888 CalPERS** (or **888-225-7377**). If the member was still employed, contact the member's employer.

Surviving family members may be eligible for health coverage, as long as they:

- Qualify for a monthly survivor check from CalPERS.
- Were enrolled or were eligible to enroll as dependents at the time of the member's death.
- Continue to qualify as eligible family members.

#### **Death of a Dependent**

If you have lost a family member and they are a dependent under your health plan, notify your employer (or CalPERS if you are retired) as soon as possible. A copy of the death certificate is required.