

Benefits Enrollment / Change Form

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
 Spouse SS# _____
 - Domestic Partnership – Declaration of Domestic Partnership from State of California is required
 Domestic Partner SS# _____

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 due to a change of address
(Complete Employee Action Request form to officially change address)
- Add eligible dependents
(Complete an Affidavit of Eligibility if adding an 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: _____

HEALTH: Check the medical plan of your choice:

- PERS Care PPO PERS Choice PPO PERS Select PPO
 Kaiser HMO PORAC (Unit 8 only)
 Blue Shield Access+ HMO 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)

DENTAL: Check the dental plan of your choice:

- Delta Dental PPO Delta Care USA: _____
(Delta Care provider's name)

Eligible Members: List the name(s), birth date(s), and relationship 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 unmarried and under the age of 23. You may not enroll your spouse if he or she is already covered by a CalPERS health plan or State of California dental plan.

Eligible Members Name	Birth Date	Relationship	Gender	Dental		Medical		Medical Provider # (Blue Shield Only)
				Add / Delete	Add / Delete	Add / Delete	Add / Delete	
_____	_____	SELF	_____	<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"/>	<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: _____ CBID: _____ PSN: _____
 TB: _____ APPT DUR: _____ EFFECTIVE DATE: _____
 Medical/FC PEC: _____ PED: _____ Dental/FC PEC: _____ PED: _____
 Verify enrollment against ACES: _____
 Verify enrollment against SCO (including vision, life insurance and LTD): _____

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, Gender Verification of Married Partners Form and your spouse's or domestic partner's Social Security number are required. Former spouses and former domestic partners are not eligible.

Your children, adopted children, or stepchildren must be under age 23 and never married - regardless of whether or not they are living with you.

A child over age 23, who has never married and 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 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 23 who has never married 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 Eligibility of Economically-Dependent Children Form (HBD-35) must be filed prior to enrollment and must be updated upon request.

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.