

# BENEFIT ENROLLMENT / CHANGE FORM

*You are required to sign and date this form before it can be processed. Please complete and return to HRM.*

**1. TYPE OF ACTION REQUESTED:** (Any changes must be submitted within 60 days of the qualifying event)

<input type="checkbox"/> <b>New Enrollment</b>	<input type="checkbox"/> <b>Add Dependent(s)</b>	<input type="checkbox"/> <b>Other: (i.e., open enrollment)</b>
<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Both	Reason: _____	Reason: _____
<input type="checkbox"/> <b>New Enrollment (Flex Cash)</b>	<input type="checkbox"/> <b>Delete Dependent(s)</b>	<input type="checkbox"/> <b>Cancel Health/Dental/Flex Cash</b>
<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Both	Reason: _____	Reason: _____

*(Please attach a copy of your medical and /or dental card to process your flex cash request)*

**Previous Employment at this or other CSU Campus**  
 Campus: \_\_\_\_\_ Date of Employment: \_\_\_\_\_

**2. EMPLOYEE INFORMATION: (PLEASE PRINT OR TYPE)**

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Department: \_\_\_\_\_ Ext: \_\_\_\_\_

**3. DEPENDENT INFORMATION: Complete information for current and/or new dependents**

To add a spouse or domestic partner for the first time, you must provide the social security number and the *Marriage Certificate or Domestic Partner Certification*.

To add a child, you must provide *the birth certificate and social security number*. To add a child other than your natural, adopted or stepchild, you must provide a notarized *"Affidavit of Eligibility"* form and copies of your tax return showing this child is your tax dependent.

Last Name	First Name	Middle Name	Relationship	Date of Birth	Action
_____	_____	_____	_____	_____	<input type="checkbox"/> Add <input type="checkbox"/> Delete
_____	_____	_____	_____	_____	<input type="checkbox"/> Add <input type="checkbox"/> Delete
_____	_____	_____	_____	_____	<input type="checkbox"/> Add <input type="checkbox"/> Delete
_____	_____	_____	_____	_____	<input type="checkbox"/> Add <input type="checkbox"/> Delete
_____	_____	_____	_____	_____	<input type="checkbox"/> Add <input type="checkbox"/> Delete

**4. HEALTH PLAN (Choose One):**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Anthem Blue Cross Select                  | <input type="checkbox"/> Anthem Blue Cross Traditional | <input type="checkbox"/> Blue Shield Access+       | <input type="checkbox"/> Blue Shield Trio |
| <input type="checkbox"/> Health Net Salud y Mas CA                 | <input type="checkbox"/> Kaiser                        | <input type="checkbox"/> PERS Gold                 | <input type="checkbox"/> PERS Platinum    |
| <input type="checkbox"/> PORAC (Restricted to employees in Unit 8) | <input type="checkbox"/> United HealthCare Alliance    | <input type="checkbox"/> United HealthCare Harmony |   |

**5. DENTAL PLAN (Choose one):**  Delta Dental (PPO)  DeltaCare (HMO) (Facility Number\*) \_\_\_\_\_

*\*If you do not select a Delta Care dentist, you will be automatically assigned to one closest to your home.*

**6. PLEASE READ CAREFULLY AND SIGN BELOW**

- I elect to **ENROLL OR CHANGE TO** the Health Benefits Plan as shown above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- I **DO NOT** wish to enroll in the Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- I elect to **CANCEL** the Health Benefits Plan shown above.

\_\_\_\_\_  
 Employee or Annuitant's Signature Date Signed