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)

☐ **New Enrollment** ☐ **Add Dependent(s)** ☐ **Other: (i.e., open enrollment)**

☐ Health ☐ Dental ☐ Both Reason: _____ Reason: _____

☐ **New Enrollment (Flex Cash)** ☐ **Delete Dependent(s)** ☐ **Cancel Health/Dental/Flex Cash**

☐ Health ☐ Dental ☐ 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: _____ SS#: _____

Address: _____
Street City State Zip Code

Home Phone: (____) _____ – _____ Date of Birth: _____ Hire Date: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

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 his/her 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.

Name	Relationship	Date of Birth	SS Number	Action
				☐ Add ☐ Delete
				☐ Add ☐ Delete
				☐ Add ☐ Delete
				☐ Add ☐ Delete
				☐ Add ☐ Delete

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

☐ Anthem Blue Cross Select ☐ Anthem Blue Cross Traditional ☐ Blue Shield Access+ ☐ Blue Shield Trio

☐ Health Net Salud y Mas CA ☐ Health Net SmartCare CA ☐ Kaiser ☐ Pers Care

☐ Pers Choice ☐ Pers Select ☐ PORAC (Restricted to employees in Unit 8)

☐ Sharp Performance Plus CA (Restricted to San Diego County) ☐ UnitedHealthCare Alliance CA

5. **DENTAL PLAN (Choose one):** ☐ Delta Dental (DPO) ☐ DeltaCare (DMO) ***(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