SONOMA STATE UNIVERSITY | Human Resources, Payroll and Benefits

Benefit Enrollment/Change Worksheet

Please return to the Payroll & Benefits Office, Salazar 2079, 707/664-2793

This worksheet shall be used to initiate enrollment or make changes to your CSU benefits. This form must be received by the Payroll and Benefits Office within 60 days of your appointment date or qualifying permitting event for timely enrollment. You have the option to voluntarily decline health and dental benefits offered by the CSU. If you do not select medical coverage (or FlexCash) within 60 days from your date of hire, then you are agreeing, by default, to decline the offer of coverage.

A – Personal Information

Employee Legal Name (First, M, Last):	Employee ID #:
Mailing Address:	Daytime Phone #:
If mailing is P.O. Box, please provide physical address:	
Marital Status: ☐ Single ☐ Married – Date of Marriage _____ ☐ Domestic Partner – Date of D.P. _____	

B – Type of Transaction

☐ New Enrollment	Date of Event: _____
☐ Add Spouse/Dependents ☐ Delete Spouse/Dependents	Reason for Change:
☐ Cancel Plan Coverage – Reason for Change:	
☐ Annual Open Enrollment – Specify Changes Requested:	
☐ Return from Unpaid Leave – Date of Return: _____ Proceed to section F (Previous plans will be reinstated)	

C – Medical Plan Selection - *Check plan you want to enroll in:*

PPO Plans: ☐ PERSCare ☐ PERS Choice ☐ PERS Select ☐ PORAC - Unit 8 Only

HMO Plans: ☐ Anthem Blue Cross Tradition ☐ Health Net SmartCare ☐ Kaiser Permanente ☐ United Healthcare ☐ Western Health Advantage

D – Dental Plan Selection - *Check plan you want to enroll in:*

☐ Delta Dental (PPO) ☐ DeltaCare USA (HMO)

FLEXCASH PLAN

☐ In lieu of health and/or dental coverage, I elect to enroll in FlexCash Health or Dental. *PLEASE COMPLETE BOX G ON REVERSE*

☐ I wish to cancel FlexCash Coverage

E – List each dependent to be enrolled, added/deleted from plan(s) – *See page 2 for required documents:*

Family Relationship	Legal Name (First, M, Last)	DOB (mm/dd/yy)	Social Security Number*	Health Add	Health Delete	Dental Add	Dental Delete	Vision Add	Vision Delete
SELF				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

F – Employee Certification – *Please read and sign below:*

- I elect to enroll in, change, and/or cancel the benefit plan(s) as indicated above
- I certify that all dependents enrolled above are eligible family members and are not enrolled in another CalPERS health plan or CSU dental plan.
- I understand that I may only make plan changes or add/delete eligible dependents during the annual open enrollment period or after submitting supporting documentation of a qualifying event.
- I understand that the effective date of benefits depends on many factors; including my first day of employment, the date I submit enrollment documents, my pay plan, and the pay period.
- I understand that I am responsible for paying benefit deductions that may be owed due to enrollment or changes in benefits coverage.

Employee's Signature: _____ **Date:** _____

Office Use only:

Supporting Documents	☐	Address Checked	☐	PS Entry	☐	PIMS deductions	☐		
Welcome Letter	☐	COBRA/HIPAA	☐	Audit CalPERS	☐	ACA Codes	☐	Eff. Date	_____

G – FlexCash Selection - *Check Plan Selected:*

In lieu of health and/or dental coverage, I wish to enroll in:

☐ FlexCash Health ($128/mo.) ☐ FlexCash Dental ($12/mo.)

If other coverage is through your spouse or domestic partner, please provide their Social Security Number: _____

I certify that I am covered by another qualifying group health plan that conforms to the Affordable Care Act's (ACA's) minimum value standards. I certify that I will maintain coverage in a qualifying group health plan on an ongoing basis and I agree to notify my campus Benefits Officer within 60 days if I lose coverage under the medical and/or dental insurance plan(s). I understand that an individual health insurance policy (for example, Covered California or another insurance marketplace) and coverage under Tricare, Medicare, and Medi-Cal are not qualifying group health plan coverage for purposes of the FlexCash Benefit Program.

I must provide proof of alternate non-CSU group coverage with the benefits worksheet.

Employee's Signature: _____ **Date:** _____

Enrollment Type	Required Copies of Supporting Documentation & Information
Active employee – **new** enrollment	N/A – If adding dependents see required documents below
Enroll or adding a **spouse**	Marriage Certificate (https://www.cdph.ca.gov/Programs/CEH/Pages/CLPR.aspx)
Enroll or adding a **registered domestic partner**	Declaration of Domestic Partnership (from the California Secretary of State's Office) http://www.sos.ca.gov/registries/domestic-partners-registry/
Enroll or adding/deleting a **Dependent**	Qualifying reason for add/delete To Add: Birth Certificate, (https://www.cdph.ca.gov/Programs/CEH/Pages/CLPR.aspx)
Enroll or adding a dependent who is in a **parent-child relationship**	Employer and/or CalPERS reserves the right to request any supporting documentation Affidavit of Parent-Child Relationship (https://www.calpers.ca.gov/docs/forms-publications/affidavit-parent-child-form.pdf)
Deleting a spouse due to divorce	Divorce Decree (Only available from the Superior Court in the county where the divorce was filed)
Deleting a registered domestic partner due to termination of partnership	Termination of Domestic Partnership submitted to the California Secretary of State's Office (http://www.sos.ca.gov/registries/domestic-partners-registry/)
Enrolling self or dependents due to **loss of other coverage**	Birth Certificate, (child) http://www.cdph.ca.gov/Programs/CEH/Pages/CLPR.aspx Marriage Certificate, (spouse) http://www.cdph.ca.gov/Programs/CEH/Pages/CLPR.aspx Declaration of Domestic Partnership (domestic partner) http://www.sos.ca.gov/dpregistry/ Need proof of coverage loss (all)
Death of employee or dependent	Need written notification of date of death

***SOCIAL SECURITY NUMBERS REQUIRED FOR ALL SUBSCRIBERS AND DEPENDENTS**

With the passage of the Health Care Reform Act in March 2010, CalPERS is required to report the Social Security members of all subscribers and their dependents. Dependents include the spouse or domestic partner and/or children. We do not need to view or have copies of Social Security cards, but are required to have the Social Security number information on file for all health/dental/vision enrolled dependents.

More detailed information can be found in the Benefits Enrollment Instructions at www.calpers.ca.gov or by calling CalPERS at 888 CalPERS (or 888-225-7377).