California State University, Sacramento

Open Enrollment Worksheet

Due in Human Resources Benefits Office by 3:00 P.M. on Friday, October 16, 2009

The following information is needed to complete any open enrollment transaction. After you submit this worksheet and any necessary additional paperwork to the Benefits Office (on or before the due date (10/16/09), you will be notified when your official paperwork is ready for signature. Any open enrollment forms not signed by Friday, October 23, 2009 will NOT be processed.

Employee Information

First Name	Last Name	Social

Address	City	State	Zip

Gender	Martial Status	Home Phone	Campus Extension	Department
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner			

Transaction Information

	Description	Medical	Dental	Vision	FlexCash	PE Code
New	New enrollment	☐	☐		☐	104/03
Change	Change from one plan to another	☐	☐			400/28
Add	Add dependents to existing coverage	☐	☐	☐		206/15
Delete	Delete dependents from existing coverage	☐	☐	☐		320
Cancel	Cancel enrollment	☐	☐		☐	530

NOTE: To cancel FlexCash and enroll in Medical/Dental, select "Cancel" FlexCash and "New" Medical/Dental.
To cancel Medical/Dental and enroll in FlexCash, select "Cancel" Medical/Dental and "New" FlexCash.

Plan Information

Medical		Dental	
Current Plan	New Plan	Current Plan	New Plan
☐ Blue Shield HMO	☐ Blue Shield HMO	☐ Delta Dental Basic (Units 8, E99, Annuitants & Fellows)	☐ Delta Dental Basic (Units 8, E99, Annuitants & Fellows)
☐ Blue Shield NetValue	☐ Blue Shield NetValue	☐ Delta Dental Enhanced I (Unit 11, & Teaching Associates)	☐ Delta Dental Enhanced I (Unit 11, & Teaching Associates)
☐ Kaiser	☐ Kaiser	☐ Delta Dental Enhanced II (Units 1, 2, 3, 4, 5, 6, 7, 9, C99, M98, M80, and FERP)	☐ Delta Dental Enhanced II (Units 1, 2, 3, 4, 5, 6, 7, 9, C99, M98, M80, and FERP)
☐ PERS Choice	☐ PERS Choice	☐ DeltaCare Basic (Units 8, 11, E99, Teaching Associates, Annuitants, & Legislative Fellows)	☐ DeltaCare Basic (Units 8, 11, E99, Teaching Associates, Annuitants, & Legislative Fellows)
☐ PERS Care	☐ PERS Care	☐ DeltaCare Enhanced (Units 1, 2, 3, 4, 5, 6, 7, 9, C99, M98, M80, and FERP)	☐ DeltaCare Enhanced (Units 1, 2, 3, 4, 5, 6, 7, 9, C99, M98, M80, and FERP)
☐ PERS Select	☐ PERS Select	DeltaCare Facility #:	
☐ PORAC	☐ PORAC		

PCP for self:

PCP for dependent:

FlexCash Enrollment Information

	Non-CSU Provider Group Name	Non-CSU Provider Group Number
Medical Waiver		
Dental Waiver		
Date gained other non-CSU coverage:		

I am currently enrolled in a state group health/dental plan and elect to add the following family member(s) to my enrollments. I understand that if enrolling a spouse under my coverage, I must provide a certified copy of my **Marriage Certificate** or sign an **Affidavit of Marriage**. I must also complete/sign an **Affidavit of Eligibility for Economically Dependent Children** in order to enroll an economically dependent child(ren) under my coverage. Domestic Partners are required to be registered by the Secretary of State, who will provide a **Declaration of Domestic Partnership** to the Domestic Partners. The following are eligible to register with the Secretary: **1.** Specified same-sex domestic partnerships between persons who are both at least 18 years of age; and **2.** Specified opposite sex domestic partnerships when one person is over 62 and both persons are over 18. The enrollee must provide a copy of the *Declaration of Domestic Partnership* and a signed *Statement of Financial Liability* to their employer. I understand that if my enrollment currently includes economically dependent children, I am required to complete and **Affidavit of Eligibility** form for ALL children enrolled.

Dependent Information

☐ Delete all dependents: ☐ Health ☐ Dental ☐ Vision

Name	Date of Birth	Relationship	SSN	Medical		Dental		Vision	
				Add	Del	Add	Del	Add	Del
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

Deletion Events

Select	Event		Date
☐	Obtained non-CSU/alternative insurance coverage	Date Coverage begins:	______/______/______
☐	Enroll as State Employee	Date Coverage begins:	______/______/______
☐	Entering Military Service	Date Coverage begins:	______/______/______
☐	Divorce. NOTE: Copy of divorce is mandatory COBRA qualifying event.	Date of final decree:	______/______/______
☐	Termination of Domestic partnership. NOTE: Copy of the Notice of Termination of Domestic Partnership. COBRA qualifying event	Date of Termination:	______/______/______
☐	Enrolls as dependent of State employee	Date coverage begins:	______/______/______
☐	Death	Date of death:	______/______/______
☐	Change of custody	Date of custody change:	______/______/______
☐	Marriage	Date of marriage:	______/______/______
☐	Over 18 years of age	Date of 18th birthday:	______/______/______
☐	Moves out of Household. NOTE: COBRA qualifying event	Date of move:	______/______/______

COBRA Qualifying Event Information

Address	City	State	Zip

______________________________ ______________________

Employee Signature Date

______________________________ ______________________

Receiving Employer Date