

# CALIFORNIA STATE UNIVERSITY, SACRAMENTO

## HEALTH/DENTAL/VISION NEW HIRE WORKSHEET

**Instructions:** Please complete the employee information and dependent information sections on this form. Indicate your health, dental, vision, and/or flex cash options below. Submit this form to Human Resources – Benefits within 60 days of your appointment date.

Effective dates are based on the date this form is received in the Human Resources - Benefits Office.

### **EMPLOYEE INFORMATION (Please print)**

**Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

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

**Home Phone:** ( ) \_\_\_\_\_ **Birth date:** \_\_\_\_\_

**Gender:**  Male  Female **Marital Status:**  Single  Married  Domestic Partnership (DP)

**Hire Date:** \_\_\_\_\_ **Campus Extension:** \_\_\_\_\_ **Email** \_\_\_\_\_

**Department:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Best time/place to be reached:** \_\_\_\_\_

Are you transferring from a CalPERS/State agency?  YES  NO Agency: \_\_\_\_\_

### **NEW ENROLLMENT SELECTIONS: Health/Dental Coverage**

I elect to join the following **health** plan:  Blue Shield HMO  Blue Shield NetValue  Kaiser  
 PERS Select  PERS Choice (\$)  PERS Care (\$\$\$)

Employee's Doctor choice: \_\_\_\_\_

Dr. Name, Group & Provider # (Blue Shield HMO and Blue Shield NetValue ONLY)

Dependent's Doctor choice: \_\_\_\_\_

Dr. Name, Group & Provider # (Blue Shield HMO and Blue Shield NetValue ONLY)

I elect to join the following **dental** plan:  \*Delta Care USA (HMO)  Delta Dental (PPO)  
*\*(Formally Delta Care PMI)*

Family Dental Office choice: \_\_\_\_\_

Dental Group Name & Provider # (DeltaCare/PMI ONLY)

I elect to enroll in the **Flex Cash** option for:  Health  Dental  Both (*Check one*)

If your coverage is through your spouse, please list their social security number: \_\_\_\_\_

Medial Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Is your spouse currently employed by a CSU?  YES  NO

*\*Please note that if electing Flex Cash, you must still provide information in order to enroll eligible dependents on your Vision Plan*

**PLEASE TURN OVER →**

# DEPENDENT INFORMATION (Please print)

Please list all dependents you wish to have covered under the appropriate sections below. Please check whether you want each dependent on medical, dental or both.

SPOUSE    or     DOMESTIC PARTNER

\* If enrolling a spouse, a copy of the marriage certificate is required.

\*\* If enrolling a Domestic Partner, a copy of the Declaration of Domestic Partnership and the Statement of Liability are required.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ M / F \_\_\_\_\_  
Full Name of Spouse or Domestic Partner    Birth Date    Gender    Social Security Number

Please enroll in:     Medical     Dental     Vision

If you are currently being covered as a dependent under another CalPERS sponsored health plan and/or a State covered dental plan you and/or your family members cannot also be covered under the CSU health and dental plan(s).

**Please answer the following questions:**

1. Is your Spouse/DP currently on a medical/dental plan through a CalPERS/State agency?  YES  NO  
If yes, please list the Agency your spouse is working for: \_\_\_\_\_
2. If yes, are you/your dependents currently enrolled on your Spouse's/DP's plan?                     YES  NO
3. Are you/your dependent(s) being deleted from this coverage? **If yes, effective date:** \_\_\_\_\_

## DEPENDENTS (children under the age of 23 years)

If enrolling a Domestic Partner's dependent child, an Affidavit of Eligibility is required. Please indicate by putting DP and either son or daughter below Relationship.

<u>Name</u>	<u>Birthdate</u>	<u>Relationship</u>	<u>Gender</u>	<u>Please check applicable</u>	<u>Social Security #</u>
_____	__ / __ / __	_____	M / F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	__ / __ / __	_____	M / F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	__ / __ / __	_____	M / F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	__ / __ / __	_____	M / F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	__ / __ / __	_____	M / F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	__ / __ / __	_____	M / F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____

I understand that my effective date is based on the date this form is received by the Human Resources Department. I also understand that I will be called to return to the Human Resources Department to sign official documents once they are typed on my behalf. I hereby certify under penalty of perjury that the information provided on this document is true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date