California State University, Sacramento – Benefit Enrollment Worksheet

The following information is needed to complete any transaction affecting health, dental, vision, and/or FlexCash coverage. After you submit this worksheet and any necessary back-up documentation to the Benefits Office, you may be required to return to sign the official enrollment form(s).

I. EMPLOYEE INFORMATION

Employee Legal Name (First and Last Name)	Date of Birth	Sex ☐M ☐F	Social Security

Physical Address	Marital Status ☐Single ☐Married ☐Domestic Partner	Preferred Contact ☐Sac State E-mail ☐Phone:
Mailing Address (if different from physical address)	Date of Marriage/Domestic Partnership	Department

Are you transferring from a CalPERS/State agency? ☐NO ☐YES, Agency: _____

Are you currently working at another CalPERS/State/Public agency? ☐NO ☐YES, Agency: _____
If YES, it is your responsibility to notify the Benefits Office should you retire from that agency.

Are you a CalPERS Retiree? ☐NO ☐YES (STOP: CalPERS Retirees are not eligible for benefits. Contact the Benefits Office for more information.)

☐ New Enrollment Date of Hire: *Proceed to Section III and continue*	☐ Change of Enrollment *Proceed to Section II and continue*

II. TRANSACTION INFORMATION

ALL transactions require supporting documentation and cannot be processed without it. Please see the reverse side for required paperwork.

Addition Events	Date of Event	Deletion Events	Date of Event
☐ Adoption		☐ Change of custody	
☐ Birth of child		☐ Death	
☐ Court Order		☐ Divorce*	
☐ Custody Change		☐ Domestic Partnership termination*	
☐ Domestic Partner		☐ Enroll as State Employee	
☐ Economically Dependent child		☐ Entering military service	
☐ Loss of Coverage		☐ Gained non-CSU/alternative coverage	
☐ Marriage		☐ Loss of Economic Dependence	
		☐ Move out of household	

*Please list ex-spouse's/ex-Domestic Partner's address:

Miscellaneous Events

☐ Change due to Move ☐ Other: Date of Event:

III. MEDICAL PROVIDER ELECTION

HMO: ☐Anthem Select ☐Anthem Traditional ☐Blue Shield Access+ ☐HealthNet ☐Kaiser ☐United Healthcare

PPO: ☐PERS Choice ☐PERS Care ☐PERS Select ☐PORAC

When selecting an HMO option, it is the employee's responsibility to contact the plan to designate a Primary Care Physician
Anthem Blue Cross: 855-839-4524, Blue Shield: 800-334-5847, HealthNet: 888-926-4921, Kaiser: 800-464-4000, United HealthCare: 877-359-3714

IV. DENTAL PROVIDER ELECTION

☐Delta Dental PPO ☐ DeltaCare USA DeltaCare Facility Name and #: _____

V. FLEXCASH ENROLLMENT INFORMATION

Per IRS regulations, alternate health coverage must be group coverage. Covered California, other Insurance Marketplaces, Tricare, Medicare, or Medi-Cal are individual plans and not eligible to receive Medical FlexCash. You must provide proof of alternate group coverage (i.e. copy of your health ID card).

Add	Del		Employer Name Offering Coverage	Non-CSU Provider Group Name	Non-CSU Provider Group #	Enrollee's SSN
☐	☐	Medical				
☐	☐	Dental				

_____ I have reviewed the FlexCash brochure describing the CSU's optional FlexCash Plan. I understand that regulations under the IRS Code require that my benefit choices authorized by this election are irrevocable during this plan year unless I have an allowable "family status change event" as defined in these regulations or other permitting events as described in the FlexCash brochure.

See reverse side for adding/removing dependents

VI. DEPENDENT INFORMATION

Is your Spouse/Domestic Partner currently on a medical/dental plan through a CalPERS/State agency? ☐NO ☐YES

If yes, please list the Agency your spouse is working for: ______________________________

If yes, are you/your dependents currently enrolled on your Spouse's/Domestic Partner's plan? ☐NO ☐YES

Are you/your dependent(s) being deleted from this coverage? If yes, effective date: ______________________________

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

Dependent Supporting Documentation Required

Your dependents must meet the eligibility criteria set by CalPERS. Refer to the CalPERS Health Program Guide for details

Spouse (adding)	Submit a copy of the Marriage Certificate and Social Security Number
Spouse (deleting)	Submit a copy of the Divorce Decree or submit a copy of Evidence Of Gaining Alternate Coverage
Registered Domestic Partner (adding)	Submit a copy of the registered Declaration of Domestic Partnership, and Social Security Number. The IRS has ruled that the actual cost of the domestic partner benefit is taxable income to the employee. Review the Domestic Partner's Benefits Tax Implication form and sign Domestic Partner Dependent Certification Form.
Registered Domestic Partner (deleting)	Submit a copy of the Termination of Domestic Partnership or submit a copy of Evidence Of Gaining Alternate Coverage
Children	Submit a copy of the child's birth certificate or adoption papers and their Social Security Number
Disabled Children Over Age 26	Submit a Member Questionnaire for the CalPERS Disabled Dependent Benefit form, and your doctor must complete and submit a Medical Report for the CalPERS Disabled Dependent form for CalPERS approval. If the disabled child has a Social Security-approved disability, you must provide CalPERS with a copy of his or her Medicare card. Provide the child's Social Security Number.
Parent-Child Relationship	Submit an Affidavit of Parent-Child Relationship, and birth certificate, and Social Security Number, and copy of recent tax return, or court order naming employee/spouse as legal guardian, or daycare receipts or school records indicating residence at employee's mailing address. Submit the Affidavit and supporting documents annually thereafter up to age 26. The Benefits Office will approve/disapprove each affidavit.

Split Enrollments	When two active or retired members are married to each other or in a domestic partnership, each member can enroll separately. However, when these individuals enroll in a CalPERS health plan in their own right, one parent must carry all dependents on one health plan. Parents cannot split enrollment of dependents. CalPERS will retroactively cancel split enrollments. You may be responsible for all costs incurred from the date the split enrollment began.
Enrolling in Two CalPERS Health Plans	Dual CalPERS coverage occurs when you are enrolled in a CalPERS health plan as both a member and a dependent or as a dependent on two enrollments. This duplication of coverage is against the law. When dual CalPERS coverage is discovered, the enrollment that caused the dual coverage will be retroactively canceled. You may be responsible for all costs incurred from the date the dual coverage began. Members may enroll in both a CalPERS health plan and a health plan provided through another employer. During Open Enrollment when adding dependents that are currently covered under another CalPERS health plan, it is your/your dependent's responsibility to submit an Open Enrollment transaction with the appropriate agency to request deletion from the other plan. We are not able to process the enrollment until the cancellation with the other plan has processed.

I have read and understand the eligibility criteria and certification documents required to enroll my dependents. I understand that I will be called to return to the Office of Human Resources - Benefits 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.

______________________________ ______________________________

Employee Signature Date

______________________________ ______________________________

Benefits Staff Signature Date