

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) | | | Preferred Contact <input type="checkbox"/> Sac State E-mail <input type="checkbox"/> Phone: | | Sac State ID or Social Security Number | |
| Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Nonbinary | | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner | | Date of Marriage/Domestic Partnership: | | |
| Physical Address | | | Mailing Address (if different from physical address) | | | |
| Are you transferring from a CalPERS/State agency? <input type="checkbox"/> NO <input type="checkbox"/> YES, Agency: _____ Are you currently working at another CalPERS/State/Public agency? <input type="checkbox"/> NO <input type="checkbox"/> YES, Agency: _____ If YES, it is your responsibility to notify the Benefits Office should you retire from that agency. Are you a CalPERS Retiree? <input type="checkbox"/> NO <input type="checkbox"/> YES (STOP : CalPERS Retirees are not eligible for benefits. Contact the Benefits Office for more information.) | | | | | | |
| <input type="checkbox"/> New Enrollment <u>Proceed to Section III and continue</u> | | | <input type="checkbox"/> Change of Enrollment <u>Proceed to Section II and continue</u> | | | |
| II. ENROLLMENT CHANGE (Supporting documentation is REQUIRED. Please see the reverse side for required documentation.) | | | | | | |
| Addition Events | | | | Date of Event | | |
| <input type="checkbox"/> Adoption <input type="checkbox"/> Birth of child <input type="checkbox"/> Court Order <input type="checkbox"/> Custody Change <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Economically Dependent child <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Marriage | | | | | | |
| Deletion Events | | | | Date of Event | | |
| <input type="checkbox"/> Change of custody <input type="checkbox"/> Death <input type="checkbox"/> Divorce* <input type="checkbox"/> Domestic Partnership termination* <input type="checkbox"/> Enroll as State Employee <input type="checkbox"/> Entering military service <input type="checkbox"/> Gained non-CSU/alternative coverage <input type="checkbox"/> Loss of Economic Dependence <input type="checkbox"/> Move out of household | | | | | | |
| *Please list ex-spouse's/ex-Domestic Partner's address: | | | | | | |
| Miscellaneous Events | | | | Date of Event | | |
| <input type="checkbox"/> Change due to Move <input type="checkbox"/> Other: | | | | | | |
| III. MEDICAL PROVIDER ELECTION | | | | | | |
| HMO: <input type="checkbox"/> Anthem Select <input type="checkbox"/> Anthem Traditional <input type="checkbox"/> Blue Shield Access+ <input type="checkbox"/> Blue Shield Trio <input type="checkbox"/> Kaiser <input type="checkbox"/> United Healthcare <input type="checkbox"/> Western Health Advant. PPO: <input type="checkbox"/> PERS Platinum <input type="checkbox"/> PERS Gold <input type="checkbox"/> PORAC When selecting an HMO option, it is the employee's responsibility to contact the plan once enrolled to designate a Primary Care Physician. | | | | | | |
| IV. DENTAL PROVIDER ELECTION | | | | | | |
| <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> 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 |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 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. | | | | | | |
| VI. PREMIER VISION ENROLLMENT INFORMATION | | | | | | |
| Premier vision is optional. Enhanced coverage is available to eligible employees within 60 days of hire or with a qualifying event. To enroll in Premier, employees must complete a paper enrollment form, and fax or mail the form to VSP. The address and fax number is listed on the form. | | | | | | |
| If an employee chooses to upgrade to Premier, any dependents to be covered in Basic will also need to be enrolled in Premier. | | | | | | |
| If an employee is enrolled in Premier, and is adding new dependent(s) to coverage, the dependent(s) will also need to be enrolled in Premier. | | | | | | |
| Employees may not split enrollments; e.g., dependent(s) in the Basic and the employee in the Premier. Eligible dependents not included in the Premier enrollment will not be able to seek services under the Basic coverage. | | | | | | |

See reverse side for adding/removing dependents

VII. 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 <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Nonbinary | Medical | | Dental | | Vision | |
|------|---------------|--------------|-----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | | | | Add | Del | Add | Del | Add | Del |
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Nonbinary | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| | | | | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Nonbinary | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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. |

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| 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