Stanislaus State
Human Resources

Benefits Worksheet

Please complete and return to the Campus Benefits Office located in MSR340. You must enroll within 60 days from your date of hire to avoid a delay in coverage. You will be contacted when official enrollment forms are ready for your signature. **Failure to complete form in its entirety may hinder processing and cause a delay in enrollment.**

SECTION A — EMPLOYEE INFORMATION *(Please print)*

□ **Faculty** □ **Staff** □ **New Enrollment** □ **Add Dependent(s)** □ **CSU Transfer Employee**
□ **Open Enrollment** □ **Delete Dependent(s)** □ **Change Plans**

Name _____ **Zip Code (Residence)** _____ **Employee CMS ID #** * _____

***CMS ID # is required – located on Warrior Card or Login to CMS Self Service Page: Self Service>Time Reporting>Employee Balance Inquiry.**

Gender: □ Male □ Female **Marital Status:** □ Single □ Married □ Domestic Partnership Marriage Date: _____ Declaration/Marriage Date: _____

Contact Number _____ **Campus Ext** _____ **Email** _____

SECTION B — ENROLLMENT DETAILS **(skip this section if selecting Open Enrollment)**

Department _____ **Date of Event** _____ **Position** _____

Reason for Enrollment or Change:
□ Marriage □ Military □ Move (*provide address below*) □ Gain of Outside Coverage
□ Newborn/Child □ New Hire □ Divorce (*provide ex-spouse name and mailing address below*)
□ Rehire
□ Loss of Outside Coverage

Ex-Spouse Name _____
Address _____

Are you transferring from or currently working for a CalPERS / State agency? □ **Yes** □ **No**

If yes, Agency Name _____ **Date coverage ends** _____

SECTION C — ENROLLMENT SELECTIONS: HEALTH/DENTAL COVERAGE or FLEX CASH

I elect to join the following health plan (choose one):

PPO Plans:
(Anthem Blue Cross)
□ PERS Care – 90/10
□ PERS Choice – 80/20
□ PERS Select – 80/20, California Based Network
□ PORAC (Police Officers only)

HMO Plans:
□ Anthem Select/Blue Cross
□ Anthem Traditional/Blue Cross
□ Blue Shield Access+
□ Kaiser Permanente
□ United Healthcare Alliance

Inquire at Campus Benefits Office regarding HMO Plan enrollment exceptions in preferred areas

I elect to join the following dental plan (choose one):

□ Delta Dental (PPO) □ Delta Care USA (HMO)* Delta Care Dental Office Choice: _____

***It is employee responsibility to ensure office accepts new patients and must provide dental office #. See list of providers online at:** www.deltadentalins.com/csu/

I elect to enroll in the Flex Cash: □ **Health** ($128.00) □ **Dental** ($12.00) □ **Both** ($140.00) ***(Check one)***

You **must** provide a completed Flex Cash Authorization form to complete enrollment.

If your health/dental coverage is through your spouse, please list their Social Security Number _____

You must provide a copy of proof of enrollment in alternative health/dental plan.

Alternative Medical Insurance Company _____ Group Number _____

Alternative Dental Insurance Company _____ Group Number _____

If electing Flex Cash, please list qualifying spouse/domestic partner information in Section E.

NOTE: Vision coverage is an automatic enrollment.

COMPLETE REVERSE SIDE

SECTION D — DEPENDENT INFORMATION *(please print)*

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

If **enrolling a spouse**, a copy of the marriage certificate and Social Security Card is **mandatory**.
If **enrolling a Domestic Partner**, a copy of the Declaration of Domestic Partnership, Statement of Liability, and Social Security Card is **mandatory**.
If **enrolling a child**, a copy of the birth certificate and social security card is **mandatory**.
If **deleting a spouse** due to divorce, a copy of divorce final judgment is **mandatory**.
Affidavit of Eligibility if enrolling dependents **OTHER THAN** spouse, domestic partner, natural/adopted child, or stepchild is **mandatory**.

Dual coverage in a CalPERS sponsored health plan is not allowed. To enroll in CSU coverage, you will need to cancel the other CalPERS sponsored health plan.

Please answer the following questions:

Is your Spouse/Domestic Partner currently on a medical plan through CalPERS? ☐ **Yes** ☐ **No** ☐ **N/A**

If yes, please list the Agency he/she is working for: _____

Are you/your dependent(s) being cancelled from this coverage? ☐ **Yes** ☐ **No**

If yes, effective date of cancellation: _____

SECTION E — ELIGIBLE DEPENDENT INFORMATION (skip this section if no dependent changes for open enrollment)

Below, list ALL eligible dependents (including self), and their Social Security Numbers. Copies of marriage certificate or domestic partnership declaration, and/or dependent children's birth certificates are REQUIRED at the time of enrollment.

Add/ Delete	Name	Birthdate	Relation	Circle Gender		Circle Selections Below			Social Security Number
		On File	Self			Medical	Dental	Both	Already on file.
				M	F	Medical	Dental	Both	
				M	F	Medical	Dental	Both	
				M	F	Medical	Dental	Both	
				M	F	Medical	Dental	Both	
				M	F	Medical	Dental	Both	
				M	F	Medical	Dental	Both	
				M	F	Medical	Dental	Both	

If there is a change in your assignment and you are no longer eligible for health benefits, they will be canceled. You will be responsible for any services rendered while ineligible for benefits.

If enrolled in FlexCash and you no longer meet the criteria for this benefit, you will be responsible for any resulting overpayment.

I understand that my effective date of enrollment is the 1st day of the month following my month of eligibility. I may see multiple deductions in subsequent months after enrollment, to cover any arrears in benefits payments, depending on the enrollment processing dates.

You have the option to voluntarily decline benefits offered by the CSU. To decline medical coverage, you must complete the CalPERS from HBD-12A. If you do not select medical coverage (or FlexCash) within the 60-day timeframe, then you are agreeing, by default, to decline the offer of medical coverage. If you take no action to enroll in benefits, then you are agreeing by default to decline benefits. For each appointment, we are required to report to the IRS on benefits offered, benefits not offered, benefits accepted, or benefits not accepted.

Signature _____ **Date** _____

NOTE: Your share of the health plan premium (if any) is paid from pre-tax dollars through the Tax Advantage Premium Plan (TAPP). You will be automatically enrolled in the TAPP. Check the following box if you elect to NOT participate in TAPP. ☐