CALIFORNIA STATE UNIVERSITY, STANISLAUS
OFFICE OF THE VICE PRESIDENT FOR FACULTY AFFAIRS AND HUMAN RESOURCES

Benefits Worksheet

Please complete and return to the Office of Faculty Affairs and Human Resources, 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** ☐ **MPP** ☐ **Staff** | ☐ **New Enrollment** ☐ **Add Dependents** ☐ **CSU Transfer Employee**
☐ **Open Enrollment** ☐ **Delete Dependents** ☐ **Change Plans**

Name ____________________ **Zip Code** __________ **Employee CMS ID #** * ____________________

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

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married Marriage Date: ____________
☐ Domestic Partnership Declaration/Marriage Date: ____________

Contact Number ______________ **Campus Ext** ________ **Email** ____________________

Department ______________ **Hire/Rehire Date** ________ **Position** ____________________

Reason for Enrollment or Change: ☐ Newborn / Child ☐ Marriage ☐ Divorce ☐ Loss of Coverage
☐ New Hire ☐ Rehire ☐ Other ____________________

Date of Event ______________

Are you transferring from or currently working for a CalPERS / State agency other than CSU Stanislaus? ☐ **Yes** ☐ **No**

If yes, Agency Name ______________________________ **Date coverage ends** __________

SECTION B ENROLLMENT SELECTIONS: HEALTH/DENTAL COVERAGE

I elect to join the following plan:

HMO Plans

☐ **Blue Shield Access Plus** * ☐ **Blue Shield NehValue** * *(Not available in Stanislaus and Merced Counties until 2013)* ☐ **Kaiser**

***Blue Shield HMO Enrollment ONLY –** Contact Blue Shield to select primary care physician*

PPO Plans (Anthem Blue Cross)

☐ **PERS Select** ☐ **PERS Choice** ☐ **PERS Care** ☐ **PORAC** **(Police Officers only)**

I elect to join the following dental plan:

☐ **Delta Dental (PPO)** ☐ **Delta Care USA (HMO)** **Delta Care Dental Office Choice:** ____________________
(It is employee responsibility to ensure office accepts new patients)

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 coverage is through your spouse, please list their Social Security Number ____________________

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 D.

NOTE: Vision coverage is an automatic enrollment.

COMPLETE REVERSE SIDE

SECTION C — 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 number is mandatory.
- If **enrolling a Domestic Partner**, a copy of the Declaration of Domestic Partnership, Statement of Liability, and social security number is mandatory.
- If **enrolling a child**, a copy of the birth certificate and social security number 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**

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 D — ELIGIBLE DEPENDENT INFORMATION

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

Add/ Delete	Name	Birth Date	Relation	Gender		Please Check One			Social Security Number
			Self	☐ M	☐ F	☐ 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	

I understand that my effective date of enrollment is the 1st day of the month following receipt of completed worksheet by the Benefits Office.

____________________________ ________________________
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. ☐