To complete and submit the Health Benefits Enrollment/Change Form please do the following:

1. Use the "Fill and Sign" Adobe tool to complete the form

** If you do not have Adobe installed on your device, you can download it for free by going to* https://get.adobe.com/reader/.
** Information on how to use the "Fill & Sign" Adobe tool can be located by going to* https://helpx.adobe.com/acrobat/using/fill-and-sign.html.

Division or Department | Optional Second Name
One University Circle | MSR300 | Turlock, CA 95382 | **T** 209.667.5555 | **F** 209.667.5555 | csustan.edu/dept

CALIFORNIA STATE UNIVERSITY, STANISLAUS
OFFICE OF THE SENIOR ASSOCIATE VICE PRESIDENT OF HUMAN RESOURCES, EO & COMPLIANCE

Benefits Enrollment/Change Form

Please complete and return to the Human Resources Office, MSR320. You must enroll within 60 days from your date of hire to avoid a delay in coverage. **Failure to complete form in its entirety may hinder processing and cause a delay in enrollment.** *Questions regarding this form can be directed to: campus Benefits Office at (209) 667-3351.*

SECTION A EMPLOYEE INFORMATION

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

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

Gender Male Non-binary Female

Marital Status Married Single Domestic Partnership Marriage Date Domestic Partnership Date

Contact Number

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

Date of Event

Reason for Enrollment/Change

New Hire Add New Born/Child Military Divorce
Rehire Loss of Outside Coverage Marriage Ex-Spouce Name
Move Gain Outside Coverage 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 Platinum-90/10
PERS Gold -80/20(California Based Network)
PORAC (Police Officers Only)

HMO Plans:

Anthem Select/Blue Cross
Anthem Traditional/Blue Cross
Blue Shield Access+
Kaiser Permanete
United Healthcare Alliance
Blue Shield Trio

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/

FlexCash Enrollment *We must receive your enrollment by the 3rd of the month for your FlexCash to be effective the 1st of the following month.*

I elect to enroll the following FlexCash plan: Health ($128) Dental ($12) Both ($140)

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.

Medical Insurance Company Group Number

Dental Insurance Company Group Number

NOTE: Vision coverage is an automatic enrollment.

COMPLETE REVERSE SIDE

SECTION D — DEPENDENT INFORMATION

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**

If yes, please list the Agency they are working for:
Are you/your dependent(s) being canceled 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	Select Gender	Select Type of Coverage	Social Security Number
		On File	Self			Already on file.

**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.*

****You have the option to voluntarily decline benefits offered by the CSU. To decline medical coverage, you must complete the CalPERS form 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.***

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

Signature

Date