

The Open Enrollment period for Medical, Dental, Vision, Flexcash, HCRA/DCRA, and Legal Plan is **September 16, 2024 through October 11, 2024**. All changes will have an effective date of **January 1, 2025**.

During Open Enrollment, you may:

- Enroll (if benefit eligible and not currently enrolled)
- Change plans
- Add or delete eligible family members (including a dependent child up to age 26)
- Cancel coverage

**** If you are NOT making any changes to your benefits, NO action is required, with the exception of enrollment in the HCRA / DCRA plans for 2025. ****

If you are making any changes, you must complete, sign and return this form **and** any supplemental forms and documentation to Human Resources, **no later than October 11, 2024**. **For health plan changes only, no additional forms are needed. For other benefit changes (noted on page 2), please submit the appropriate enrollment form(s), which are found on the [Open Enrollment website](#), along with this worksheet.**

Section 1: Employee Information		
Employee's Name (First - MI - Last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Home Address (Number & Street, City, State & Zip Code)	Social Security #: ____ - ____ - ____	<input type="checkbox"/> Domestic Partner (DP)

Section 2: Dependent Information
Please fill out ONLY if adding a spouse, domestic partner, and/or a dependent child (up to age 26) to your insurance.

Is your spouse/ DP a state or county employee? Yes No If yes, please specify employer: _____

Please make sure you have included the following copies of these documents (if applicable):

<input type="checkbox"/> Spouse: Marriage Certificate	Domestic Partners (DP)* (These forms can be found on the Benefit Forms webpage)
<input type="checkbox"/> Dependent Child: Birth Certificate	<input type="checkbox"/> Declaration of Domestic Partnership
	<input type="checkbox"/> Certificate of Financial Liability
	<input type="checkbox"/> DP Dependent Certification Form

***NOTE to DP's:** If adding a DP to health and/or dental insurance, there are certain tax liabilities involved. Please consult your tax advisor for further information.

Section 3: Health Plans**
Please make the following changes to my health coverage (check all that apply):

ENROLL / CHANGE health plan to: _____
(list all dependents to be covered in Section IV)

CANCEL my health plan in: _____

ADD dependent(s) (Spouse, DP and/or a dependent child up to age 26) (List dependents in Section IV)

DELETE dependent(s) (List dependents in Section IV)

(next page)

Section 4: Health/Dental - Additions/ Deletions Information

Please list **ALL** individuals to be added to or deleted from Health and/or Dental coverage.

Health Add Delete		Dental Add Delete		First Name	M.I.	Last Name	Social Security Number	Date of Birth Mo-Day-Yr	Relationship to Employee
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Section 5: Dental Plans

In addition to filling out the information in Section IV above, please fill out the **Dental Enrollment Authorization Form** found at: <https://csumb.edu/hr/open-enrollment>

Enroll / Change Dental Plan to: Delta Dental Level II Enhanced PPO
 DeltaCare USA Enhanced (HMO)
 Cancel coverage

Section 6: Vision Plan – VSP Premier Plan (Employee-Paid)

For **VSP Premier Vision Plan** enrollment, changes or cancellation - You **must** contact VSP directly by either using their website (<http://csuactives.vspforme.com>) or by calling them at **1-800-400-4569**. See **2025 Vision Plan Summary** for premium information. No VSP Premier Enrollment forms will be processed by the campus or VSP.

Section 7: FlexCash

I elect to enroll in the FlexCash Program and receive a cash reimbursement in lieu of enrollment in medical and/or dental plans, or elect to cancel my FlexCash enrollment. Complete a **FlexCash Enrollment Authorization form** available at: <https://csumb.edu/hr/open-enrollment>

Program	Monthly Cash Reimbursement	
Health & Dental	<input type="checkbox"/>	\$140
Health Only	<input type="checkbox"/>	\$128
Dental Only	<input type="checkbox"/>	\$ 12
Cancel	<input type="checkbox"/>	\$ 0

**Section 8: Dependent Care Reimbursement Account (DCRA)
Health Care Reimbursement Account (HCRA)**

The CSU *Dependent Care Reimbursement Account (DCRA)* and *Health Care Reimbursement Account (HCRA)* offers you the ability to pay for eligible out-of-pocket health care expenses and dependent care expenses with pre-tax dollars. The 2025 annual contribution limit for the HCRA plan is \$3,200 and for the DCRA plan is \$5,000. To continue participation in either of these two plans, you must **re-enroll annually** during Open Enrollment by completing the **2025 DCRA/HCRA enrollment form** found at: <https://csumb.edu/hr/open-enrollment>

Note: For more information about these benefit programs, visit the Benefits website at: <https://csumb.edu/hr/open-enrollment>. For questions, please contact Human Resources Benefits office at ext. 4426, Human Resources’s main desk at ext. 3389, or email benefits@csumb.edu. **ALL** enrollment forms require signatures via Adobe Sign or manual signature.

PLAN EARLY! All Health, Dental, Flexcash and HCRA/DCRA forms must be received by Human Resources no later than October 11, 2024. Incomplete forms or forms received after this date will not be accepted.

Employee Signature: _____ Date: _____