

## **Benefits Additions & Deletions Worksheet**

Please return completed forms and any corresponding documentation within 60 days from your permitting event date (i.e. loss of coverage, marriage, birth of child, divorce, etc.) to University Personnel/Benefits in Tide Hall. Forms received after the 60-day deadline will be subject to a 90-day waiting period.

Section I: Employee Information						
				ex	Morito	l Ctatus
Employee's Name (First- Mide			EX Female	Marital Status		
Mailing Address (Number & Street, City, State & Zip		p Code)		ecurity #:	Single Married Domestic Partner (DP)	
Campus Bidg. Was your last employer a CalPERS agency or another CSU campus? Yes No If yes, please specify:						
Are you currently covered under spouse or DP insurance? Yes No  If yes, please specify employer:						
<u> </u>						
Section II: Dependent Information						
- Please fill out ONLY if adding a spouse, domestic partner, and/or a dependent child to your insurance.						
Is your spouse/ DP a state or county employee?						
Please make sure you have included the following copies:						
Spouse: Marriage Certificat	e	Domes	tic Partners	(DP)* (These form	ns can be found or	n the Forms webpage)
Dependent Child: Birth Certificate  Declaration of Domestic Partnership  Certificate of Financial Liability  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 representative for further information.						
Section III: Health & Denta	Additions/ Dolotio	ne Information				
Please list all individuals to be a						
		n Health (H) and/or	Dental (D) co	overage.		
Add Delete  ✓ First Name	M.I. Last Name	n Health (H) and/or Social Security Number	Date of Birth	Relationship to Employee	Permitting Event Date	Reason for Change
Add Delete		Social Security	Date of	Relationship		
Add Delete  ✓ First Name		Social Security Number	Date of Birth	Relationship		
Add Delete  ✓ First Name		Social Security Number	Date of Birth	Relationship		
Add Delete  ✓ First Name		Social Security Number	Date of Birth	Relationship		
Add Delete  ✓ First Name		Social Security Number	Date of Birth Mo-Day-Yr	Relationship		
Add Delete  H D H D  First Name    C   C   C   C    H D D D D D D D D D D D D D D D D D D		Social Security Number	Date of Birth Mo-Day-Yr	Relationship		
Add Delete  H D H D  First Name  H D D D  Health Plan:	M.I. Last Name	Social Security Number  Dental Plan**	Date of Birth Mo-Day-Yr	Relationship to Employee		
Add Delete  H D H D  First Name  H D D D  H D  H D D  H D  H D D  H D	M.I. Last Name	Social Security Number  Dental Plan**:	Date of Birth Mo-Day-Yr	Relationship to Employee	Event Date	Change
Add Delete  H D H D  First Name  H D H D  Health Plan:  Section IV: **Dental & Vis  Dental Plan Enrollment - In	M.I. Last Name  ion Enrollment - Adaddition to filling out the	Social Security Number  Dental Plan**:  dditions / Deletion e information in Sec	Date of Birth Mo-Day-Yr	Relationship to Employee	Event Date	Change
Add Delete  H D H D  H D H D  Health Plan:  Section IV: **Dental & Vis  Dental Plan Enrollment - In  Authorization Form found on the section is section.	ion Enrollment - Adaddition to filling out the he University Personner	Social Security Number  Dental Plan**:  dditions / Deletion e information in Security et Forms webpage a	Date of Birth Mo-Day-Yr  s Informatio ction III above and submit wi	Relationship to Employee  on  a, please fill out th this workshee	the <b>Dental En</b> et.	Change
Add Delete  H D H D  First Name  H D H D  Health Plan:  Section IV: **Dental & Vis  Dental Plan Enrollment - In	ion Enrollment - Adaddition to filling out the he University Personnerment - If you are enrol	Social Security Number  Dental Plan**:  dditions / Deletion e information in Security et Forms webpage a	Date of Birth Mo-Day-Yr  S Informatio ction III above and submit wi	Relationship to Employee  on e, please fill out th this workshee and need to ma	the <b>Dental En</b> et.	Change  prollment  your covered
Add Delete  H D H D  Health Plan:  Section IV: **Dental & Vis  Dental Plan Enrollment - In  Authorization Form found on t  Vision Premier Plan Enroll  dependents, please complete a submit with this worksheet.	ion Enrollment - Adaddition to filling out the he University Personner ment - If you are enrol VSP Premier Vision E	Social Security Number  Dental Plan**:  dditions / Deletion e information in Sec of Forms webpage a  liled in VSP Premie Enrollment form to	Date of Birth Mo-Day-Yr  S Informatio ction III above and submit wi	Relationship to Employee  on e, please fill out th this workshee and need to ma	the <b>Dental En</b> et.	Change  prollment  your covered
Add Delete  H D H D  H D H D  Health Plan:  Section IV: **Dental & Vis  Dental Plan Enrollment - In  Authorization Form found on t  Vision Premier Plan Enroll  dependents, please complete a  submit with this worksheet.  Section V: Employee Sign  I ELECT TO ENROLL in (or MAKE C  my share of the cost of enrollment	ion Enrollment - Adadition to filling out the he University Personner went - If you are enroll VSP Premier Vision Enature & Acknowled CHANGES TO) the benefits as it is now or as it may be	Social Security Number  Dental Plan**:  dditions / Deletion e information in Security of Forms webpage at the second form to t	Date of Birth Mo-Day-Yr  Is Information III above and submit with a cated on the cooperand agree TIFY that the ir	Relationship to Employee  on e, please fill out th this workshee and need to ma University Persone to authorize ded formation provid	the <b>Dental En</b> et.  ke changes to onnel Forms welluctions from my	change  proliment  your covered peppage and  y salary to cover
Add Delete  H D H D  Health Plan:  Section IV: **Dental & Vis  Dental Plan Enrollment - In  Authorization Form found on to  Vision Premier Plan Enroll  dependents, please complete as submit with this worksheet.  Section V: Employee Sign  I ELECT TO ENROLL in (or MAKE O	ion Enrollment - Addition to filling out the he University Personner went - If you are enroll VSP Premier Vision Enature & Acknowled CHANGES TO) the benefits as it is now or as it may be abers as defined in the Public eners to understand the be	Social Security Number  Dental Plan**:  dditions / Deletion e information in Security e information in Security e information in Security e information in Security e plans as indicated all e in the future. I CER blic Employees' Medicated. able). I AGREE to rea	Date of Birth Mo-Day-Yr  s Information and submit with the including and agree TIFY that the including and Hospital differences and Hospital diffe	Relationship to Employee  In Explease fill out the this worksheet and need to ma University Personal Care Act.  The to authorize dediffermation provided Care Act.  The to authorize dediffermation provided Care Act.	the Dental Enet. ke changes to onnel Forms welluctions from myed herein is accoverage (EOC) a	change  aroliment  your covered yebpage and  y salary to cover urate and listed  and any