



New Employee Benefits Enrollment Worksheet

Please return completed forms and any corresponding documentation within 60 days from your hire date to Human Resources (Tide Hall). Forms received after the 60-day deadline will be subject to a 90-day waiting period.

Section 1: Employee Information		
Employee's Name (First- Middle Initial- Last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)
Mailing Address (Number & Street, City, State & Zip Code)		
Campus Bldg. & Room #:	Was your last employer a CalPERS contracted agency or another CSU campus? If yes, please specify: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	
Campus Extension:	Are you covered as a dependent under another health plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Section 2: Dependent Information	
<i>Please fill out ONLY if enrolling a spouse, domestic partner, and/or a dependent child to your insurance.</i>	
Is your spouse/ DP a state or county employee? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please specify employer: _____
Please make sure you have <u>included</u> the following copies with your enrollment documents:	
<input type="checkbox"/> Spouse: Marriage Certificate	Domestic Partners (DP)* -
<input type="checkbox"/> Dependent Child: Birth Certificate	<input type="checkbox"/> Domestic Partnership Certificate from CA Secretary of State
	<input type="checkbox"/> Domestic Partner Tax Dependent Certification form (available on <i>Benefits Forms</i> webpage)
*NOTE for DP coverage: If adding a DP to health and/or dental insurance, there are certain tax liabilities involved. Please consult with your tax representative for further information.	

Section 3: Health Insurance		
PPO Options:	HMO Options:	Unitedhealthcare HMO
<input type="checkbox"/> PERS Platinum	<input type="checkbox"/> Anthem Select HMO	
<input type="checkbox"/> PERS Gold	<input type="checkbox"/> Anthem Traditional HMO	
<input type="checkbox"/> PORAC (Unit 8 only)	<input type="checkbox"/> Blue Shield Access+ HMO	Primary Care Doctor:
Waived	<input type="checkbox"/> Blue Shield Trio HMO	(HMO plans only) _____
	<input type="checkbox"/> Kaiser Permanente HMO	
Medical ID cards are mailed 7–10 business days from when the carrier completes your enrollment. The health effective date will be the 1 st of the month following the date your completed form is received by Human Resources.		

Section 4: Dental Insurance (employer-paid) – Please fill out and attach the <i>Dental Enrollment Form</i>	
Units 1, 2, 3, 4, 5, 6, 7, 8, 9 and C99, M98, and FERP Annuitants:	The dental effective date is the first of the month following the date your completed form is received by Human Resources/ Benefits.
<input type="checkbox"/> Delta Dental Level II Enhanced (PPO)	
<input type="checkbox"/> DeltaCare Enhanced (HMO)	
Unit E99 (Excluded), and Annuitants only:	<input type="checkbox"/> Delta Dental Basic (PPO)
Units 10, 11 (Teaching Associates), and 12 only:	<input type="checkbox"/> DeltaCare Basic (HMO)
<input type="checkbox"/> Delta Dental Level I Enhanced (PPO)	Waived

Section 5: Enrollment Selections & Dependent Information									
Please list all individuals (including yourself) to be enrolled in health, dental, and/or vision coverage.									
First Name	M.I.	Last Name	Social Security Number	Date of Birth Mo-Day-Yr	Relationship to Employee	Health <input checked="" type="checkbox"/>	Dental <input checked="" type="checkbox"/>	VSP Vision	
			- -		SELF	<input type="checkbox"/>	<input type="checkbox"/>	<i>Basic</i>	<i>Premier</i>
			- -			<input type="checkbox"/>	<input type="checkbox"/>		
			- -			<input type="checkbox"/>	<input type="checkbox"/>		
			- -			<input type="checkbox"/>	<input type="checkbox"/>		

Section 6: FlexCash – If you are not enrolling in CSU health and/or dental insurance and wish to enroll in FlexCash, please complete the **FlexCash Enrollment Authorization Form**, and include a copy of your non-CSU group health and/or dental insurance ID cards.

I elect to enroll in the following:	Cash Amount per month:	Please list your alternative non-CSU coverage:		
<input type="checkbox"/> Health Only	\$128	Health Insurance Co:		Group #:
<input type="checkbox"/> Dental Only	\$ 12	Dental Insurance Co:		Group #:
<input type="checkbox"/> Health & Dental	\$140	Waived		

Section 7: Health Care/ Dependent Care Reimbursement Accounts (HCRA/ DCRA) – Please fill out and attach the **Health Care/ Dependent Care Enrollment Form**.

I elect to enroll in the following:	Amount per month: Refer to enrollment form for min. & max amounts.	If your completed form is received in Human Resources by the 5 th of the month, your account(s) will be effective the 1 st of the month following. Otherwise, eff. date will be 2nd month.
<input type="checkbox"/> HCRA	\$	
<input type="checkbox"/> DCRA	\$	
<input type="checkbox"/> Not at this time		

These accounts MUST be renewed every year during the annual Open Enrollment period, if enrollment is to continue.
Failure to do so will result in the termination of your HCRA/ DCRA account at the end of the plan year (December 31st).

Section 8: Employer-Paid Life, AD&D, and LTD Insurance - Informational Purposes Only

Per your assigned unit, you have automatically been enrolled in the following benefits.

<u>Unit</u>	<u>Life</u>	<u>AD&D</u>	<u>LTD</u>
2, 5, 7, 9 (CSUEU)	50K	50K	N/A
3	50K	50K	66 2/3% of \$15,000 after 180 days
4	25K	25K	66 2/3% of \$15,000 after 180 days
6, 10	N/A	N/A	N/A
8 (SUPA)	50K	50K	N/A
C99	50K	50K	66 2/3% of \$15,000 after 180 days
M80*	100K	100K	66 2/3% of \$15,000 after 180 days
M98*	250K	250K	66 2/3% of \$22,500 after 180 days

* **MPP's only:** Employer paid life insurance exceeding \$50,000 has an imputed income tax liability, which will be reported in accordance with IRS regulations.

Please waive additional life insurance (units M80 & M98 only)

Section 9: Voluntary Benefits (Optional)

If you are interested in any of the voluntary benefits below, please visit the respective websites of these providers to enroll:

- **Accident Insurance, Critical Illness Insurance, Life Insurance or AD&D:** <https://www.standard.com/mybenefits/csu/index.html>
- **Auto & Home/Renters Insurance:** <https://www.calcas.com/csu>
- **Legal Insurance:** <http://www.araglegal.com/CSU>
- **Pet Insurance:** <https://benefits.petinsurance.com/the-california-state-university>
- **403(b) Voluntary Retirement plan:** www.netbenefits.com/calstate (CSU-sponsored plan)
- **401(k) and 457 Voluntary Retirement plans:** <https://www.savingsplusnow.com> (CA-state sponsored plans)

Section 10: Employee Signature and Acknowledgment

I ELECT TO ENROLL in the benefits plans as indicated above and agree to authorize deductions from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future. I CERTIFY that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan (if applicable). I AGREE to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

Should any life changes occur to me or my dependents that would affect their benefits, I will notify Human Resources/Benefits within 60 days of the life event date.

Signature:

Date: