Channel Islands
CALIFORNIA STATE UNIVERSITY

Benefit Worksheet

PLEASE RETURN FORM TO HUMAN RESOURCES PROGRAMS
SOLANO HALL, ROOM 1123

1. Type of Action (Check One)
   - ☐ NEW ENROLLMENT
   - ☐ CHANGE of COVERAGE
     _____
     (List reason: Marriage, Birth of Child, etc.)
   - ☐ CANCEL COVERAGE
   - ☐ OPEN ENROLLMENT
   - ☐ FLEX CASH ☐ Health ☐ Dental

   (Proof of coverage is required at time of enrollment, i.e., ins. card.)

   New HCRA Enrollment $ _____

   New DCRA Enrollment $ _____

2. Permitting Event Date
   (Month/Day/Year)

   _____

   (Examples include: Date of Hire, Date of Marriage, Child's Date of Birth)

   Date of Hire

   _____

3. (For Benefits Use Only)

   Effective Date: _____
   (Month/Day/Year)

4. (For Benefits Use Only)

   Employee ID No. _____

5. Employee's Name: _____
   (First) (MI) (Last)

   Mailing Address: _____

   City, State, Zip: _____

   E-Mail Address: _____

   Phone: _____

6. Employee's Social Security No:

7. Employee's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner

8. Spouse's/Domestic Partner's Social Security No: _____

9. Name of Health Plan: _____

10. Name of Dental Plan: ☐ Delta Dental Premier/PPO ☐ DeltaCare USA Dental Provider _____
    (no dental provider required for Premier/PPO) City or Office Number_____

11. List all eligible dependents you wish to enroll in medical and/or dental coverage. Please be sure to include yourself.
    - To enroll a spouse, you must provide a copy of your marriage certificate/Affidavit of Marriage and spouse's Social Security Number.
    - To enroll a Domestic Partner, you must provide your "Declaration of Domestic Partnership" from the Secretary of State and your Domestic Partner's Social Security Number
    - To enroll a child, you must provide a copy of their birth certificate
    - To enroll a child who is economically dependent (but is not your natural, adopted, or stepchild), you must complete an Affidavit of Eligibility for the child.
    - Relationship descriptions (not all inclusive): Adopted daughter, adopted son, daughter, domestic partner, domestic partner's child, son, spouse, stepdaughter, or stepson.

Action Code A = Add D = Delete	(First) (MI) (Last)	Date of Birth (Month/Day/Yr)	Social Security Number	Relationship	Plan Type (Health/Dental/Both)
A				Self	

I hereby elect to enroll in (or change) a Health and/or Dental Plan as shown in Items 9 and 10 above, and authorize deductions to be made from my salary or retirement allowance 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 names of all dependents listed above in item 11 are eligible for coverage.

_____ _____ _____
Employee Signature Date Work Phone

Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS (225-7377)
TDD - (916) 795-3240
FAX (916) 795-1277

Declaration of Health Coverage: HBD-12A **(INSTRUCTIONS ON REVERSE)**

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER _____-_____-_____	NAME (PRINT) (FIRST) (MIDDLE) (LAST) _____ _____ _____
PART A ☐ I elect to enroll myself and all eligible dependents.	
PART B ☐ I elect to enroll myself. My eligible dependents have other health insurance coverage.	If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment **within 60 days** from the date on which you lose coverage. **If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90-day waiting period or the Open Enrollment effective date.**
PART B-2 ☐ I elect to enroll myself and all eligible dependents. I also have eligible dependents who have other health insurance coverage.	
PART C-1 ☐ I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.	
PART C-2 ☐ I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.	You can request enrollment for yourself and/or your dependents at any time. **You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.**

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for you dependent, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependent, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

_____ _____ _____

Member's Signature | Date Signed | Health Benefits Officer's Signature

Original: Employee's Personnel File | Copy: Employee

Rev (1/05)