



Name: _____
First M.I. Last

Employee SS#: _____

(Must complete EAR form to officially change address)

Address: _____
Number and Street City State Zip Code

Sex: Male Female Home Phone: _____ Campus Phone: _____

Marital Status: Single Married-marriage certificate or affidavit of marriage required. Spouse SS# _____
 Domestic Partnership-Declaration of Domestic Partnership & Statement of Financial Liability req'd
DomesticPartner SS# _____

Check action to be taken:

- New Enrollment- eligible for benefits but not currently enrolled
- Open Enrollment Change
- Add eligible dependents, state reason and date: _____ Date: _____
Adding children who are economically dependent on you require that an Affidavit of Eligibility be on file
- Delete Dependents, state reason and date: _____ Date: _____
In the case of divorce, you must provide a copy of the final decree
- Cancel Plan

Please check the medical plan of your choice or FlexCash:

- Blue Shield Access+ HMO Kaiser HMO PERSCare PPO PERSChoice PPO FlexCash
- Blue Shield NetValue HMO PERS Select (must complete FlexCash Form)

Please check the dental plan of your choice: Delta Dental DeltaCareUSA: _____ (provider #)

Please list below name, birth date, and relationship of all family members to be covered (including yourself). If adding or deleting a family member, please check Add or Delete in the space provided. Please use an additional sheet if necessary. All dependents listed, other than spouse or domestic partner, must be unmarried and under the age of 23. You may not enroll your spouse if he or she is already covered by a CalPERS health plan or State of California dental plan.

Family Members	Birth Date	Relationship	Dental		Medical		Medical Provider # (Blue Shield Plans Only)
			Add/Delete	Add/Delete	Add/Delete	Add/Delete	
_____	_____	SELF	<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"/>	_____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

I elect to enroll in (or change to) health benefits plans as shown above and authorize deductions to be made 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 also certify that the names of all dependents listed above are eligible family members as defined in the Public Employees' Medical and Hospital Care Act and that they are not enrolled in another CalPERS medical plan or State of California dental plan.

Signature: _____

Date: _____

Human Resources Use Only:

Reason Code:

Qualifying Event:

Qualifying Event Date:

HBO Received Date:

Coverage Begin Date

Health Enrollment Reason Codes

Reason Description	Reason Code	Event Date	Effective Date Method	Required Document(s)
New Employee	100	Date of Appointment	2	
Loss of coverage	101	Date other coverage ends	2	Proof of loss of coverage
Adding Newborn or newly adopted child	200	Date of birth, date of adoption or placement for adoption	1M	Birth certificate or adoption papers
Adding New Spouse or Step-children due to Marriage	201	Date of Marriage	2	Marriage Certificate
Deleting dependent who reaches age 23	301	Dependent's 23 rd birth date	1M	
Deleting dependent(s) due to Divorce	302	Date of Divorce	1M	Copy of divorce decree
Deleting dependent that obtains other coverage	307	Date other coverage begins	1P	Proof of other coverage

Effective Dates

Effective Date Number	Effective Date Method Description
1	1 st day of the month following the Event Date (Mandatory Event) or HBO Received Date (Permissive)
2	1 st day of the month following the HBO Received Date if within 60 days of the Event Date. If the HBO Received Date is beyond the 60 th day, the effective date is the 1 st day of the month following a 90-day waiting period from the HBO Received Date (Permissive Event).