CSUDH | PAYROLL SERVICES & BENEFITS
1000 E. Victoria Street- WH 478 Carson, CA 90747
(310) 243-3769 | FAX (310) 217-6889

BENEFITS ENROLLMENT WORKSHEET

Name: ___________________________ **Marital Status**:__________________ **SSN#**:_____________________________

Address:____
Number of Street City State Zip Code

Contact Phone #:_____________________ **Contact Email**: ___________________________ **From another CSU?**_____

TYPE OF ACTION

Enroll in Plan
[ ]Health [ ]Vision
[ ]Dental [ ]HCRA/DCRA
[ ]Flex Cash Health
[ ]Flex Cash Dental

Cancel Plan
[ ]Health [ ]Vision
[ ]Dental [ ]HRCA/DCRA
[ ]Flex Cash Health
[ ]Flex Cash Dental

Add/Delete Dependent
[ ]Health
[ ]Dental
[ ]Vision

Change Plan
[ ]Health
[ ]Dental
[ ]HCRA/DCRA

REASON FOR ACTION:____ **DATE OF ACTION**:______________

PLAN OPTION

MEDICAL PLAN SELECTION:____(plans listed on back of page)

DENTAL PLAN SELECTION:____(plans listed on back of page)

FLEX CASH ENROLLMENT: *Must provide proof of alternative non-CSU employer coverage. Must provide a copy of the marriage certificate and spouse's full social security number, if covered through spouse. It is not retroactive.*

CURRENT HEALTH PLAN ($128/month)____________________________________ **GROUP #**______________

CURRENT DENTAL PLAN ($12/month)_____________________________________ **GROUP #**______________

DEPENDENT INFORMATION

First Name	Last Name	SSN #	Birthdate	Relationship	Health		Dental		Vision	
					Add	Delete	Add	Delete	Add	Delete

PLEASE INCLUDE A COPY OR COPIES OF THE REQUIRED DOCUMENT(S) FOR ALL DEPENDENT(S) LISTED ABOVE:

[ ]Marriage Certificate
[ ]Divorce Decree
[ ]Death Certificate
[ ]Declaration of Domestic Partnership
[ ]Dissolution of Domestic Partnership
[ ]Affidavit of Parent/Child Relationship
[ ]Birth Certificate
[ ]Adoption Certificate

Employee Signature:____ **Date**:___________________

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ACKNOWLEDGEMENT &
Missed Premium Accounts Receivable Agreement

The CSU Benefits Summary is intended to provide an overview of the benefits generally available to CSU employees. This is a summary of benefits and should not be construed as a substitute for the master contracts or official plan documents. More detailed information about each of our benefit plans can be found in the individual plan summaries and official plan documents. If you need copies of these materials, please visit individual health plan's website.

Carrier premium and coverage information may change during your employment at CSUDH as a result of collective bargaining, changes in legislation, or CalPERS vendor contract negotiations. You will receive advance written notification from the carrier, CSU, and/or Payroll Services and Benefits office of any such changes affecting your benefits.

If you have recently moved, please make sure your most recent address is updated in ***MyCSUDH Portal*** to ensure you receive important benefits and tax information in a timely manner.

Please note the following effective dates:

Medical/Dental: Coverage begins on the first day of the month following receipt of the enrollment forms and required documents to Payroll Services and Benefits office in WH 478, within 60-days from date of eligibility or hire to avoid a 90 day waiting period.*

Flexcash: The effective date is the first day of the second month following receipt of the enrollment forms and supporting documents to Payroll Services and Benefits in WH 478, within 60-days from date of eligibility or hire.

Vision: The CSU provides two vision plans for all eligible employees and their dependents. Employees who are eligible for benefits will be automatically enrolled in the basic plan effective the 1st of the month after their hire date for staff, and beginning of eligible semester for Faculty. Employees have 60 days from eligibility or hire date to enroll in the optional premier plan for a fee.

** Note for Faculty: For Fall semester enrollees, medical, dental, and vision coverage is effective Oct. 1st for enrollment forms submitted by Sept. 30th. Forms submitted in October (within the 60-day limit) will be effective Nov. 1st for medical, dental, and vision. For Spring semester enrollees, medical, dental, and vision coverage is effective March 1st for enrollment forms submitted by Feb. 28th. Forms submitted in March (within the 60-day limit) will be effective April 1st for medical, dental, and vision.*

I, ______________________________ understand that due to the different timelines for processing my benefit enrollment elections, my health premium(s), Health Care Reimbursement, Dependent Care Reimbursement deduction(s) or cancellation of Flex Cash, it may not be processed in a timely manner by the State Controller Office to reflect on my first pay warrant. I understand I am responsible for paying the retroactive deduction(s) for the health, Health Care Reimbursement or Dependent Care Reimbursement enrollment and/or cancellation of Flex Cash. Notification will be sent by Payroll Services and Benefits upon establishment of an account receivable and will provide mutually agreed repayment option plans.

My signature below indicates I am aware of the possible retroactive health premium(s), Health Care Reimbursement, Dependent Care Reimbursement or cancellation of Flex Cash account receivable and agree to repayment in a timely manner based upon a mutually agreed payment option.

______________________________ ______________________________

Employee Name (Printed) Employee ID number

______________________________ ______________________________

Signature Date

CalPERS

Member Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715
(888) CalPERS (or **888**-225-7377)
TTY (877) 249-7442
FAX (800) 959-6545

Declaration of Health Coverage: HBD-12A

(INSTRUCTIONS ON REVERSE)

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME (FIRST)	(MIDDLE)	(LAST)
_____-_____-_____	__________	__________	__________

PART A ☐ I elect to enroll myself and all eligible dependents.	
PART B-1 ☐ 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 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 your dependents, 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 dependents, 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

INSTRUCTIONS – DECLARATION OF HEALTH COVERAGE (HBD-12A)

Please contact your Health Benefits Officer if you have any questions regarding the HBD-12A.	
Employee Information	Complete with the appropriate employee information.
Part A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
Part B-1:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage
Part B-2:	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
Part C-1:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
Part C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

Special rules to consider for retirement and death:

Retirees: you are eligible to enroll in a CalPERS health plan if you meet all of the criteria below:

- Your retirement date is within 120 days of separation from employment
- You are eligible for health benefits upon separation
- You receive a monthly retirement allowance
- You retire from the State, California State University (CSU), or an agency that currently contracts with CalPERS for health benefits

Survivor Death Benefit: your dependents may enroll in a CalPERS health plan as a survivor as long as they:

- Are eligible for enrollment as a dependent on the date of death of a CalPERS retiree
- Receive a monthly survivor check
- Continue to qualify as an eligible family member

Dependents who are enrolled at the time of the employee or annuitant's death and meet the eligibility requirements can continue the health enrollment as a survivor. Dependents who are not enrolled and meet the eligibility requirements may enroll in a health plan within 60 days of the employee or annuitant's death, or during Open Enrollment.

The effective date of enrollment is the first day of the month following the date CalPERS receives the request. Exceptions may apply for certain contracting agency survivors who do not receive a monthly survivor check. Your survivor will need to contact your former employer for additional information.