California State University
SAN MARCOS

Benefits Enrollment Worksheet

SECTION A: EMPLOYEE INFORMATION

Employee Name: ______________________ PeopleSoft ID: ______________

Contact Number: ______________ Contact Email: ______________ Gender: ☐ Male ☐ Female Marital Status: ______________

Residence Address: *(Street - No P.O. Box)* *(City)* *(State)* *(Zip Code)*

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SECTION B: ENROLLMENT ACTIONS

Action Type: ______________ **Multiple Action Details (if applicable):** ______________

Permitting Event: ______________ **Permitting Event Date:** ______________

SECTION C: CalPERS Health Coverage Decision

To enroll in a Health Plan, carefully review the information in this section and check the box :

☐ **I ELECT TO ENROLL** in (or **MAKE CHANGES TO**) a health benefits plan as indicated on page 2 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. **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 the 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.

To decline a Health Plan, carefully review the information in this section and check the box:

☐ ***I DECLINE ENROLLMENT*** into the CalPERS Health Program for myself and my dependents.

I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE Period before I can enroll. The effective date of coverage will be the first of the month following the 90 day waiting period or the next OE effective date.

Employee Signature: Date:

You have the option to voluntarily decline benefits offered by the CSU. If you do not select medical coverage (or FlexCash) within the 60-day timeframe, then you are agreeing, by default, to decline the offer of medical coverage. Participants in the CSU Benefit plans must notify the HR Benefits Office of any changes in your family situation (i.e., marriage, divorce, change of address, etc.) within 60 days of the event date. Failure to notify HR of a family status change may result in financial liability for any costs due to late notifications and correction of retroactive benefits coverage. Review the CalPERS Health Program for details on eligiblity, deadlines and family status changes.

SECTION D: ENROLLMENT ELECTIONS

CalPERS Heath Plan Options (Select One) ______________________

Dental Plan Options (Select One) ______________________

Use Work ZIP code for Health Eligibility when Health Plan not available under your residential Zip code**:** Yes No

Enter DeltaCare - Facility ID: ______________

If you are currently enrolled in a CalPERS Health Plan outside of CSU San Marcos, List Campus/Employer: ______________________

Vision Plan Options (Select One): ______________________

Basic Vision is an automatic enrollment for Employee and Family; VSP Premier requires a separate Enrollment Form to complete process

FlexCash Plan ***(In lieu of a CSU Health &/or Dental):*** ______________________

* FlexCash Plan: Alternative Coverage Information (*Complete the below and provide a copy(s) of the insurance card(s) if you choose cash in lieu of CSU offered health and/or dental coverage.)*

I certify that I am covered by another qualifying group health plan that conforms to the Affordable Care Act's (ACA's) minimum value standards. I certify that I will maintain coverage in a qualifying group health plan on an ongoing basis and I agree to notify my HR Benefits Office within 60 days if I lose coverage under the medical and/or dental insurance plan(s). I understand that an individual health insurance policy (i.e., from Covered California or another insurance marketplace) and coverage under TriCare, Medicare and Medi-Cal are not qualifying group health plan coverage for purposes of the FlexCash Benefit Program.

I have read and agree to the terms and conditions of the FlexCash Program as outlined in the FlexCash Brochure.

Alternative Coverage Information

Medical Insurance Carrier/Policy #: ______________________

Dental Insurance Carrier/Policy #: ______________________

Complete this section ONLY if your "other" non-CSU medical and/or dental insurance it through your spouse's (or domestic partner's) plan(s):

Spouse's (or domestic partner's) SSN: ______________

SECTION E: Subscriber and Dependent Information *(List yourself and all of your dependents to be enrolled, added or removed on your plan(s); SSN required - if not previously provided. Provide copies of Marriage Certificate or Declaration of Domestic Partnership required for spouse/domestic partner, copies of Birth Certificates required for dependent children, if not previously provided.*

Name (First, M.I., Last)	Social Security #	Date of Birth	Relationship	Health		Dental		Vision	
				Add	Del	Add	Del	Add	Del
	ON FILE	ON FILE	SELF						

Relationship Codes: **S** - Spouse **DP** - Domestic Partner **NC** - Natural Child **SC** - Step Child **AC** - Adopted Child **DPC** - DP Child **PCR** - Parent Child Relationship

SECTION F: For Employer Use Only

Completed by: ______________

Notes:

	Sent	Posted
CalPERS		
SCO		

CalPERS Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code Sections (20000 et. seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to the CalPERS system and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy, or your rights, please write the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call our Customer Contact Center at 888-CalPERS (888-225-7377).

Privacy Information

Submission of the requested information is mandatory. This information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

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