ACA Enrollment Worksheet

Complete this form and bring the required **original** documents to HR Benefits in SH – Rm. 113. Our office will make a copy of them for your file.

Employee Information

Employee Name:	Coyote ID # (if known):	Social Security Number:	
Home Street Address:	City:	State:	Zip:
Home Phone #:	Cell Phone #:	Campus Ext.: X7	Email Address:
Marital Status:	Gender:	Campus Department:	Bargaining Unit No. (if known):

Event (refer to back page): _____ **Hours worked per week:** _____ **Event Date:**_____

Enroll in Plan	Cancel Plan	Add/Delete Dependent
☐ Health ☐ HCRA/DCRA	☐ Health ☐ HCRA/DCRA	☐ Health
☐ FlexCash Health	☐ FlexCash Health	

Plan Option

Medical Plan Selection (list of plans on the back of this sheet)

Health Plan:_____

FlexCash Enrollment: Medical cards from other employer-sponsored coverage must be presented to show proof of coverage.

____Health ($128/month) Health Plan: _____ Group #: _____

Dependent Information: Please make sure you have checked off the boxes below and included the **original** documents, if applicable. N/A ☐

Spouse:	Domestic Partner:	Dependent Child:
☐ Marriage Certificate	☐ Declaration of Domestic Partnership	☐ Birth Certificate
☐ Social Security Card	☐ Social Security Card	☐ Social Security Card
☐ Proof of Residency	☐ Proof of Residency	☐ Adoption Certificate
☐ Divorce Decree	☐ Dissolution of Domestic Partnership	☐ Affidavit of Parent/Child Relationship
☐ Death Certificate	☐ Death Certificate	☐ Death Certificate

Dependent Enrollment Selections N/A ☐

First Name	Last Name	Social Security #	Birthdate (mm/dd/yy)	Relationship & Gender	Health	
					add	del.

I hereby elect to enroll in the above health plan and I understand that my effective date for this plan is based on the date the official documents are received by HR- Benefits. **In addition, I understand that I will be contacted to return and sign the official documents.**

Signature: _____ Date: _____

Questions? **Call HR Benefits:** (909) 537- 5143 **E-mail:** benefits@csusb.edu Rev. 02/18

Events:

- Newly hired, newly eligible, marriage, divorce, childbirth, child adoption, custody change, loss/gain of coverage, death etc.
    - COBRA Notice/HIPAA notification is required to show proof of loss of other coverage.

Medical Plans:

- Anthem SELECT
- Anthem Traditional
- Blue Shield Access+
- Health Net Salud Y Mas
- Health Net Smartcare
- Kaiser
- Sharp- San Diego Only
- United HealthCare
- PERS-CARE PPO
- PERS Choice PPO
- PERS Select PPO
- PORAC PPO- R08 only

FlexCash

Medical cards from other employer-sponsored coverage must be presented to show proof of coverage. If coverage is through your spouse, please include their Social Security Number below on the additional information or comment box. Employees enrolled in individual medical plan coverage including, but not limited to, Tricare, Medicare, Medi-Cal and Covered California are NOT eligible to receive FlexCash in lieu of CalPERS medical coverage even if the coverage provides minimum value. We MUST receive your enrollment by the 5th of the month for your FlexCash to be effective the 1st of the next month.

Dependents

CalPERS guidelines for enrolling family members (eligible dependents) are as follows:

- **Spouse or domestic partner** can be added to your health plan if done within 60 days after the date of your marriage or registration of your domestic partnership. Former spouses and former domestic partners are not eligible.
    - **Marriage Certificate/Declaration of Domestic Partnership**
    - **Social Security Card**
    - **Proof of Residency** (ex.- utility bill, front page of previous year taxes showing the same address as employee, etc.)
- **Children** are eligible for health coverage up to age 26. They are eligible even if they are married, do not live with you, or are not students. Eligible children are defined as natural, adopted, step or domestic partner's children under age 26. If your dependent is married you may not enroll their spouse or children (unless the child is an economic dependent of the employee).
    - **Birth Certificate(s) or Adoption Papers**
    - **Social Security Card(s)**
- **Children over the age of 26** that are incapable of self-support due to a mental or physical condition that existed prior to age 26, may be included when you first enroll.
    - **A Questionnaire for the CalPERS Disabled Dependent Benefit Form (HBD-98) and Medical Report for the CalPERS Disabled Dependent Benefit Form (HBD-34) must be approved by CalPERS prior to enrollment and must be updated upon request.**
- Another person's child under age 26 may be eligible for coverage if you have been granted custody or joint custody by a court or the child resides with you.
    - **Birth Certificate**
    - **Social Security Card**
    - **Affidavit of Eligibility of Economically-Dependent Children Form (HBD-35) must be filed prior to enrollment and must be updated upon request.**

Dual Coverage

You cannot be enrolled in a CalPERS health plan as a member and a dependent or as a dependent on two enrollments. This is called dual coverage and it is against the law. When dual coverage is discovered the coverage will be retroactively canceled. You may have to pay for all costs incurred from the date the dual coverage began.

Please use this area for additional information or comments: