California State University
MONTEREY BAY
Human Resources

New Employee
Benefits Enrollment Worksheet

Please return completed forms and any corresponding documentation within 60 days from your hire date to Human Resources (Tide Hall). Forms received after the 60-day deadline will be subject to a 90-day waiting period.

Section 1: Employee Information

Employee's Name (First- Middle Initial- Last)

Mailing Address (Number & Street, City, State & Zip Code)

Sex
☐ Male ☐ Female

Marital Status
☐ Single ☐ Married
☐ Domestic Partner (DP)

Campus Bldg. & Room #:

Campus Extension:

Was your last employer a CalPERS contracted agency or another CSU campus? If yes, please specify: Yes ☐ No ☐

Are you covered as a dependent under another health plan? Yes ☐ No ☐

Section 2: Dependent Information

Please fill out ONLY if enrolling a spouse, domestic partner, and/or a dependent child to your insurance.

Is your spouse/ DP a state or county employee? Yes ☐ No ☐ If yes, please specify employer:

Please make sure you have included the following copies with your enrollment documents:

☐ **Spouse:** Marriage Certificate

☐ **Dependent Child:** Birth Certificate

Domestic Partners (DP)* -

☐ Domestic Partnership Certificate from CA Secretary of State

☐ Domestic Partner Tax Dependent Certification form (available on *Benefits Forms* webpage)

****NOTE for DP's:** If adding a DP to health and/or dental insurance, there are certain tax liabilities involved. Please consult with your tax representative for further information.*

Section 3: Health Insurance

PPO Options:

☐ **PERS Platinum**
☐ **PERS Gold**
☐ **PORAC *(Unit 8 only)***

HMO Options:

☐ ***Anthem Select HMO***
☐ ***Anthem Traditional HMO***
☐ ***Blue Shield Access+ HMO***
☐ ***Blue Shield Trio HMO***
☐ ***Kaiser Permanente HMO***
☐ ***Unitedhealthcare HMO***

Primary Care Doctor:
(HMO plans only)

Medical ID cards are mailed 7–10 business days from when the carrier completes your enrollment. The health effective date will be the 1st of the month following the date your completed form is received by Human Resources.

Section 4: Dental Insurance (employer-paid) – Please fill out and attach the *Dental Enrollment Form*

Units 1, 2, 3, 4, 5, 6, 7, 8, 9 and C99, M98, and FERP Annuitants:

☐ **Delta Dental Level II Enhanced (PPO)**
☐ **DeltaCare Enhanced (HMO)**

Units 10, 11 (Teaching Associates), and 12 only:

☐ **Delta Dental Level I Enhanced (PPO)**

The dental effective date is the first of the month following the date your completed form is received by Human Resources/ Benefits.

Unit E99 (Excluded), and Annuitants only:

☐ **Delta Dental Basic (PPO)**
☐ **DeltaCare Basic (HMO)**

Section 5: Enrollment Selections & Dependent Information

Please list all individuals (including yourself) to be enrolled in health, dental, and/or vision coverage.

First Name	M.I.	Last Name	Social Security Number	Date of Birth Mo-Day-Yr	Relationship to Employee	Health ✓	Dental ✓	VSP Vision	
								Basic	*Premier*
			- -		**SELF**	☐	☐	☐	☐
			- -			☐	☐	☐	☐
			- -			☐	☐	☐	☐
			- -			☐	☐	☐	☐

Section 6: FlexCash – If you are not enrolling in CSU health and/or dental insurance, please fill out and attach the ***FlexCash Enrollment Authorization Form,*** along with a copy of your non-CSU group health and/or dental insurance ID cards.

I elect to enroll in the following:	Cash Amount per month:	Please list your alternative non-CSU coverage:			
☐ Health Only	$128	Health Insurance Co:		Group #:	
☐ Dental Only	$ 12	Dental Insurance Co:		Group #:	
☐ Health & Dental	$140	If your completed FlexCash form is received in Human Resources by the 5th of the month, your Flexcash will be effective the 1st of the month following.			

Section 7: Health Care/ Dependent Care Reimbursement Accounts (HCRA/ DCRA) – Please fill out and attach the ***Health Care/ Dependent Care Enrollment Form***.

I elect to enroll in the following:	**Amount per month:** Refer to enrollment form for min. & max amounts.
☐ HCRA	$
☐ DCRA	$
☐ Not at this time	

If your completed form is received in Human Resources by the 5th of the month, your account(s) will be effective the 1st of the month following. Otherwise, eff. date will be 2nd month.

These accounts MUST be renewed every year during the annual Open Enrollment period, if enrollment is to continue. Failure to do so will result in the termination of your HCRA/ DCRA account at the end of the plan year (December 31st).

Section 8: Employer-Paid Life, AD&D, and LTD Insurance - Informational Purposes Only
Per your assigned unit, you have automatically been enrolled in the following benefits.

Unit	Life	AD&D	LTD
2, 5, 7, 9 (CSUEU)	50K	50K	N/A
3	50K	50K	66 2/3% of $15,000 after 180 days
4	25K	25K	66 2/3% of $15,000 after 180 days
6, 10	N/A	N/A	N/A
8 (SUPA)	50K	50K	N/A
C99	50K	50K	66 2/3% of $15,000 after 180 days
M80*	100K	100K	66 2/3% of $15,000 after 180 days
M98*	250K	250K	66 2/3% of $22,500 after 180 days

*** MPP's only**: Employer paid life insurance exceeding $50,000 has an imputed income tax liability, which will be reported in accordance with IRS regulations.

☐ **Please waive additional life insurance (units M80 & M98 only)**

Section 9: Voluntary Benefits (Optional)

If you are interested in any of the voluntary benefits below, please visit the respective websites of these providers to enroll:

- **Accident Insurance, Critical Illness Insurance, Life Insurance or AD&D**: https://www.standard.com/mybenefits/csu/index.html
- **Auto & Home/Renters Insurance:** https://www.calcas.com/csu
- **Legal Insurance:** http://www.araglegal.com/CSU
- **Pet Insurance:** https://benefits.petinsurance.com/the-california-state-university
- **403(b) Voluntary Retirement plan:** www.netbenefits.com/calstate (CSU-sponsored plan)
- **401(k) and 457 Voluntary Retirement plans:** https://www.savingsplusnow.com (CA-state sponsored plans)

Section 10: Employee Signature and Acknowledgment

I ELECT TO ENROLL in the benefits plans as indicated above 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 (if applicable). 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 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.

Should any life changes occur to me or my dependents that would affect their benefits, I will notify Human Resources/Benefits within 60 days of the life event date.

Signature: _____ Date: _____