California State University
MONTEREY BAY
University Personnel

Benefits Additions & Deletions Worksheet

Please return completed forms and any corresponding documentation within 60 days from your permitting event date (i.e. loss of coverage, marriage, birth of child, divorce, etc.) to University Personnel/Benefits in Tide Hall. Forms received after the 60-day deadline will be subject to a 90-day waiting period.

Section I: Employee Information

Employee's Name (First- Middle Initial- Last)	**Sex** ☐Male ☐Female	**Marital Status** ☐ Single ☐ Married ☐ Domestic Partner (DP)
Mailing Address (Number & Street, City, State & Zip Code)	**Social Security #:** - -	

Campus Bldg. & Room #:		**Was your last employer a CalPERS agency or another CSU campus?** ☐Yes ☐No If yes, please specify: _____
Campus Extension:		**Are you currently covered under spouse or DP insurance?** ☐ Yes ☐ No If yes, please specify employer: _____

Section II: Dependent Information

- Please fill out ONLY if adding 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:

☐ **Spouse:** Marriage Certificate

☐ **Dependent Child:** Birth Certificate

Domestic Partners (DP)* *(These forms can be found on the Forms webpage)*

☐ Declaration of Domestic Partnership
☐ Certificate of Financial Liability
☐ DP Dependent Certification Form

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

Section III: Health & Dental Additions/ Deletions Information

Please list all individuals to be added to or deleted from Health (H) and/or Dental (D) coverage.

Add ✓		Delete ✓		First Name	M.I.	Last Name	Social Security Number	Date of Birth Mo-Day-Yr	Relationship to Employee	Permitting Event Date	Reason for Change
H	D	H	D								
☐	☐	☐	☐				- -				
☐	☐	☐	☐				- -				
☐	☐	☐	☐				- -				
☐	☐	☐	☐				- -				

Health Plan:		**Dental Plan**:**	

Section IV: **Dental & Vision Enrollment - Additions / Deletions Information

Dental Plan Enrollment - In addition to filling out the information in Section III above, please fill out the ***Dental Enrollment Authorization Form*** found on the *University Personnel Forms webpage* and submit with this worksheet.

Vision Premier Plan Enrollment - If you are enrolled in VSP Premier Vision plan and need to make changes to your covered dependents, please complete a ***VSP Premier Vision Enrollment form*** located on the University Personnel Forms webpage and submit with this worksheet.

Section V: Employee Signature & Acknowledgment

I ELECT TO ENROLL in (or MAKE CHANGES TO) 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.

Signature: _____ **Date:** _____