CALIFORNIA STATE UNIVERSITY, FRESNO

2018 Open Enrollment Health Benefits Worksheet

This document must be received by HR, Joyal Administration Bldg, ***Room 211 by 5:00 p.m. on Friday, October 5, 2018***

Section 1: Type of Transaction – Check all that apply

Employee's Legal Name	FresnoState ID	Staff/Administrator	Faculty
Mailing Address (street, city, state, zip) **Update new address at *MyFresnoState* (Self-Service) or Payroll Services.**	Home/Cell Phone	Email	

Section 2: Type of Transaction – Check all that apply

Change MEDICAL plan from ____________________ **to** ____________________ **Select new plan in SECTION 3**

Change DENTAL plan from ____________________ **to** ____________________ **Select new plan in SECTION 4.**

Change: Add / Delete Dependent(s)
Complete SECTION 3 & 4: Select current Medical/Dental plan for adding/deleting dependent(s).
SECTION 5: List dependent(s) to add/delete

Change: Enroll in FLEXCASH			**Change: Cancel FLEXCASH**		
Cancel	Medical plan:__________	Dental plan:________	**Cancel**	FlexCash Medical ($128)	FlexCash Dental ($12)
Enroll in	FlexCash Medical ($128)	FlexCash Dental ($12)	**Enroll in**	Medical plan	Dental plan
ATTACH FlexCash form & copy of proof of alternate NON-CSU coverage .			**Select Medical and/or Dental plan(s) from Section 3 & 4 (below).** **ATTACH FlexCash Program form and appropriate dependent documents (e.g. birth certificate, marriage certificate, domestic partnership)**		

New Enrollment – Eligible for benefits but not currently enrolled in any plan. Select Plan(s) in SECTION 3 & 4 (below).

Section 3: Medical Plan Options – Check plan selected

Anthem Blue Cross Select* (HMO)	Anthem Blue Cross Traditional* (HMO)	BlueShield Access+ Advantage*(HMO)	Health Net SmartCare* (HMO)	Kaiser* (HMO)	United HealthCare Alliance* (HMO)
PERSChoice(PPO)	PERS Select(PPO)	PERS Care(PPO)	PORAC (PPO) This medical plan is restricted to Unit 8 employees with SUPA membership.		

*If electing an HMO, are you requesting employer zip code for health plan eligibility? (HMO plans are based on your residence's zip code)

Section 4: Dental Plan Options - Check plan selected

DELTA DENTAL (PPO) | DELTA CARE USA (HMO) Specify provider name and facility:______________________________

Section 5: IMPORTANT INFORMATION FOR NEW ENROLLMENTS AND CHANGES

- **ADDING DEPENDENTS or SPOUSE/DOMESTIC PARTNER**: ATTACH APPROPRIATE DOCUMENTS
  - A ***Certificate of Live Birth*** and Social Security number are required for each eligible dependent.
  - Marriage Certificate or Declaration of Domestic Partnership and Social Security number is required.
- **CHANGES: List all currently enrolled dependents for all plans (including yourself) then circle "Add" or "Delete" or "Continue" (currently enrolled).**

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

If spouse or domestic partner is **employed or retired** from CSU system, State civil service, CalPERS Public Agency/School or CALSTRS are you a dependent on their health plans? No Yes Agency: ____________________

RELATIONSHIP CODE	CIRCLE Gender	LEGAL - NAME (FIRST, M.I., LAST)	SSN	Medical	Dental	DATE OF BIRTH	CIRCLE ACTION
SELF	F M						Add Delete Continue
S or DP	F M						Add Delete Continue
	F M						Add Delete Continue
	F M						Add Delete Continue
	F M						Add Delete Continue
	F M						Add Delete Continue

Section 6: Enrollment - To enroll/decline, carefully review the information in this section and check the box:

I ELECT TO ENROLL/MAKE CHANGES TO a health benefits plan 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. **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.

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 OE effective date.

Employee Signature: | **Date:** *(mm/dd/yyyy)*

OFFICE USE: Pending-- ☐ Copy of Marriage Certificate or Declaration of Domestic Partnership ☐ SSN(s) and/or copy of Birth Certificate(s)
Documents Received:

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.

SSN

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. The 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.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

IMPORTANT: It is your responsibility to notify your Human Resources 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 Human Resources office may result in adverse consequences.