

California State University, Fresno

2014 Open Enrollment Benefit Worksheet

This document must be received by HR, Joyal Administration Room 211 **by 5:00 p.m. on Friday, October 10, 2014.**

SECTION 1. Employee's Information

Employee's Legal Name		Fresno State ID:		<input type="checkbox"/> Staff/Administrator	<input type="checkbox"/> Faculty
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Bargaining Unit: _____		
If ADDING Spouse or Domestic Partner Is spouse or domestic partner employed by CSU, State civil service or a CalPERS Public Agency? <input type="checkbox"/> NO <input type="checkbox"/> YES -- Employer:					
Address (Number & Street, City, State & Zip) <i>If address has changed, please update your address using myFresnoState (Employee Self-Service).</i>					
Department	Office Ext. ☎	Home/Cell Phone ☎	E-Mail ✉		

SECTION 2. Type of Transaction – Check as many as apply:

<input type="checkbox"/>	Change Health/Dental Plan <input type="radio"/> MEDICAL plan from _____ to _____ <input type="radio"/> DENTAL plan from _____ to _____		
<input type="checkbox"/>	Change: Add Dependent(s) - List dependent(s) in SECTION 4. * Review back of worksheet for eligibility and required document(s).*		
<input type="checkbox"/>	Change: Delete Dependent(s) - List dependent(s) in SECTION 4.		
<input type="checkbox"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> Change: Enroll in FLEXCASH Cancel <input type="checkbox"/> Medical plan <input type="checkbox"/> Dental plan Enroll in <input type="checkbox"/> FlexCash Medical(\$128) <input type="checkbox"/> FlexCash Dental(\$12) ATTACH FlexCash form & copy of proof of alternate NON-CSU coverage </td> <td style="width: 50%; vertical-align: top;"> Change: Cancel FLEXCASH Cancel <input type="checkbox"/> FlexCash Medical (\$128) <input type="checkbox"/> FlexCash Dental(\$12) ATTACH FlexCash Cancellation form and appropriate documents (e.g. birth certificate, marriage certificate, domestic partnership) Enroll in <input type="checkbox"/> Medical plan <input type="checkbox"/> Dental plan Select Medical and/or Dental plan(s) from Section 3 (below). </td> </tr> </table>	Change: Enroll in FLEXCASH Cancel <input type="checkbox"/> Medical plan <input type="checkbox"/> Dental plan Enroll in <input type="checkbox"/> FlexCash Medical(\$128) <input type="checkbox"/> FlexCash Dental(\$12) ATTACH FlexCash form & copy of proof of alternate NON-CSU coverage	Change: Cancel FLEXCASH Cancel <input type="checkbox"/> FlexCash Medical (\$128) <input type="checkbox"/> FlexCash Dental(\$12) ATTACH FlexCash Cancellation form and appropriate documents (e.g. birth certificate, marriage certificate, domestic partnership) Enroll in <input type="checkbox"/> Medical plan <input type="checkbox"/> Dental plan Select Medical and/or Dental plan(s) from Section 3 (below).
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<input type="checkbox"/>	New Enrollment – Eligible for benefits but not currently enrolled in any plan. Select Plan(s) in SECTION 3 (below).		

SECTION 3. Medical Plan Options – Check new plan selected

<input type="checkbox"/> Anthem Blue Cross Select*(HMO)	<input type="checkbox"/> Anthem Blue Cross Traditional*(HMO)	<input type="checkbox"/> BlueShield Access + Advantage*(HMO)	<input type="checkbox"/> PORAC (PPO) --- Unit 8 (This medical plan is <u>restricted</u> to SUPA membership.)
<input type="checkbox"/> BlueShield NetValue Advantage*(HMO) employees	<input type="checkbox"/> Kaiser*(HMO)	<input type="checkbox"/> United HealthCare Alliance*(HMO)	
<input type="checkbox"/> PERSChoice (PPO)	<input type="checkbox"/> PERS Select (PPO)	<input type="checkbox"/> PERS Care (PPO)	

*Zip Code Election: If you are not eligible to enroll in an HMO plan based on your residence's zip code and you wish to enroll in an HMO based on California State University, Fresno's zip code, an additional form must be completed. PLEASE CONTACT HUMAN RESOURCES (559) 278-2032.

Dental Plan Options – Check new plan selected

<input type="checkbox"/> DELTA DENTAL (PPO)	<input type="checkbox"/> DELTA CARE USA (HMO) Specify provider name & facility: _____ If no provider is listed, Delta Care will assign provider.
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SECTION 4. IMPORTANT INFORMATION FOR OPEN ENROLLMENT REQUEST

- **NEW ENROLLMENTS:** List all eligible dependents (including yourself) to be enrolled in health and/or dental plan.
- **CHANGES:** List all currently enrolled dependents (including yourself) for all plans with "N/A" action. Then list any new dependents to be added or deleted. Check reverse side of this form for required documentation for adding a dependent.

Relationship	CIRCLE Gender	LEGAL- NAME (FIRST, M.I., LAST)	SOCIAL SECURITY#	Medical	Dental	Vision	DATE OF BIRTH	CIRCLE ACTION		
SELF	F M			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Add	Delete	No Change
	F M			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Add	Delete	No Change
	F M			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Add	Delete	No Change
	F M			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Add	Delete	No Change
	F M			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Add	Delete	No Change
	F M			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Add	Delete	No Change
	F M			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Add	Delete	No Change

Please check each statement & sign below.

- I understand that my changes noted above will become **effective January 1, 2015.**
- I understand my request to make health plan change(s) will be processed electronically based on this *2014 Open Enrollment Benefits Worksheet.*
- I understand that in order to add dependent(s), a **SSN(s) and copy of Birth Certificate(s)** for each dependent is required within one week of submitting this request if not provided at the time of this request. **Guidelines and Dependent requirements on reverse side.**

Employee's Signature: _____ **Date:** _____

OFFICE USE: Pending-- Copy of Marriage Certificate or Declaration of Domestic Partnership SSN(s) and/or copy of Birth Certificate(s)
 Notified-- E-mail sent _____ Follow-up phone call home or office _____

Completed-- Documents Received: _____

OPEN ENROLLMENT

During the open enrollment period, eligible employees may enroll as “new”, change plans, or add/delete eligible dependents to their health plans. Open Enrollment requests will be accepted beginning September 15, 2014 – October 10, 2014 by 5:00 p.m. Based on the CalPERS and State Controller’s deadlines and processing time, no exceptions can be made.

CALPERS GUIDELINES & DEPENDENT INFORMATION

All health plans require a Social Security number and a copy of Birth Certificate for each dependent.

***Eligible Dependent(s) - Additional required documentation for adding dependents are noted below:**

- **Spouse** (opposite-sex and same-sex) **and Domestic Partners** (same-sex over the age of 18 or opposite sex-partners if over the age of 62). Requires a *copy of Marriage Certificate or Domestic Partnership*. Former spouses or former domestic partners are not eligible.
- **Natural children, stepchildren or adopted children under the age of 26** regardless of whether or not they are living with you or marriage status. Social Security number(s) in addition to a copy of birth certificate, adoption papers or other supporting documents are required.
- **Disabled Child** over age 26, who is incapable of self support due to a mental or physical condition that existed prior to age 26, may be eligible to enroll in your health plans. 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 CalPERS request. Please contact Human Resources for additional information (559) 278-2032.
- **Other:** Another person's child under the age of 26 in a Parent-Child Relationship. (Contact Human Resources for additional paperwork - Affidavit of Parent-Child Relationship (HBD-40) and documentation must be provided for each dependent upon request for enrollment and if approved, documentation is required each year to continue dependent(s) on-going enrollment.)

Split Enrollments: Members who are married and who both work or worked (retirees), for agencies in the CalPERS Health Program can enroll separately. If you and your spouse enroll separately, you must enroll all eligible family members, regardless of the relationship, under only one of you. Dependents cannot be split between parents. For example, if a CalPERS member with children marries another CalPERS member with children and each member has their own enrollment in the CalPERS Health Program, all children must be enrolled under one parent. The effective date of coverage will be the first of the month following the date of marriage. If split enrollments are discovered, they will be retroactively corrected. You will be responsible for all costs incurred from the date the split enrollment began.

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.

Family Status Changes Outside of Open Enrollment

Although CalPERS administers our health plans, all changes **MUST** be coordinated through Human Resources. It is the employee's responsibility to notify Human Resources within 60 days when there are any changes in their family status in order to add/delete eligible dependent(s). Additions and deletions of eligible dependents are effective the first of the month following the permitting event or receipt of Benefits Worksheet and documentation.

Family Status Changes include:

- Marriage and Domestic Partnership (**Requires Copy of Marriage Certificate or Declaration Domestic Partnership**);
- Birth of a child, Adoption, or Acquisition of a dependent child (Parent-Child Relationship); *
- Eligible dependent moves out;
- Divorce, Legal Separation and Death (documentation required)

If eligible dependent(s) are not added or deleted within 60 days of a Family Status Change, dependent(s) may be added during Open Enrollment (Mid-September through Early-October) and will become effective the following plan year on January 1st.