HEALTH & DENTAL BENEFITS ENROLLMENT WORKSHEET

Agency Use Only

ACES Batch #_______________

1. TYPE OF ACTION:

☐ **NEW** enrollment

☐ **CHANGE** of coverage

☐ **CANCEL** all coverage

2. CSUB ID: ______________________________

3. Sex: Male ☐ Female ☐

4. Name: ______________________________

Home Phone: ____________________ Campus Ext.: ____________________

5. Married: ☐ Yes ☐ No

5A. SPOUSE'S SOCIAL SECURITY NUMBER (**Required if not adding as a dependent**)

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6. NAME OF **HEALTH** PLAN

CURRENT: ____________________

NEW: ____________________

7. NAME OF **DENTAL** PLAN

CURRENT: ____________________

NEW: ____________________

8. If you are **adding** or **deleting** a family member (s), please indicate reason for addition/deletion i.e. divorce (**final divorce document required**), marriage (**marriage certificate required**), dependent child (**affidavit of eligibility required**), birth/adoption (**adoption certificate required**), and **date** of occurrence.

REASON: ______________________________ DATE: ____________

Forwarding address of family member **deleted**: ______________________________

SSN	FAMILY MEMBERS	BIRTHDATE	RELATIONSHIP	ADD/ DELETE	PRIMARY PHYSICIAN /FACILITY

It is understood that State procedures prohibit the staff of the Human Resources Office from making value judgments concerning the relative merits of the insurance plans. I certify that the family members listed are eligible dependents as defined in the Public Employee Medical and Hospital Care Act and understand that falsifying dependent information will result in termination of coverage and liability for past premiums and medical expenses. It is further understood that the staff of the Human Resources Office does not act as agents for the insurance plan carriers and problems concerning claims and information concerning coverage must be handled directly with the carriers. The Information Practices Act of 1977 and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals. Information requested on this form will be used by the CalPERS Board of Administration, the State Controller's Office and the health and/or dental insurance company for purposes of identification and insurance coverage processing. It is mandatory to furnish all information requested on this form.
Failure to provide the information requested may result in the enrollment action not being processed or processed incorrectly.

YOU HAVE 60 DAYS FROM THE DATE OF THE ELIGIBLE APPOINTMENT TO ENROLL IN A HEALTH AND DENTAL PLAN. Medical plan effective dates will be the first of the month following the date an active employee turns in this worksheet. Dental plan effective dates will be the first of the second month.

AGY ________ PEC ________
UNIT ________ PED ________
CBID ________ EFF ________

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(Signature) (Date)

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