CAL MARITIME

BENEFITS ENROLLMENT/CHANGE WORKSHEET
ACA Notification

PLEASE COMPLETE AND SUBMIT THIS FORM TO THE DEPARTMENT OF HUMAN RESOURCES **WITHIN 60 DAYS** OF YOUR APPOINTMENT DATE.

EMPLOYEE INFORMATION (Please Print)

Name (First, M, Last): _____Social Security Number: _____

Mailing Address: _____

Phone Number: _____ Date of Birth_____ Gender ☐ Female ☐ Male ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership Date of Marriage/DP: _____

Hire Date: _____ Department: _____ Position: _____

PLEASE ANSWER ALL OF THE FOLLOWING:

Are you transferring from a CalPERS/State Agency? ☐ No ☐ Yes, Agency _____

Are you currently working at another CalPERS/State/Public Agency? ☐ No ☐ Yes Agency_____

If YES, it is YOUR responsibility to notify the Department of Human Resources should you retire from that Agency (Please Initial) _____

Are you a CalPERS Retiree? ☐ No ☐ Yes

NEW ENROLLMENT SELECTIONS (Health):

☐ I elect to enroll in the following **health** plan:

☐ Anthem Blue Cross Select ☐ Anthem Blue Cross Traditional ☐ Blue Shield Access ☐ Blue Shield TRIO
☐ Health Net SmartCare ☐ Kaiser ☐ PERS Platinum PPO (formerly PERS Choice PPOand PERS Care PPO)
☐ PERS Gold PPO(formerly PERS Select PPO) ☐ Police Officers Research Association of California (PORAC) PPO
☐ Sharp Health Plan (available only in So. Cal) ☐ United HealthCare ☐ Western Health Advantage

☐ I elect to enroll in the **FlexCash*** option for ☐ Health

Alternate Insurance Coverage: Subscriber's Social Security Number: _____

Medical Insurance Company: _____Group Number: _____

Is your Spouse/Domestic Partner currently employed by a CSU? ☐ No ☐ Yes, CSU: _____

If electing FlexCash, you must provide proof of coverage.

PLEASE TURN OVER ⟶

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DEPENDENT INFORMATION (Please Print)

Please list all dependents you wish to have covered under the appropriate sections below. Please check the appropriate benefit coverage you are electing for each dependent.

☐ Spouse or ☐ Domestic Partner

If enrolling a spouse, a copy of the marriage certificate is required

****If enrolling a Domestic Partner, a copy of the Declaration of Domestic Partnership is required. Review the Domestic Partner's Benefits Tax Implication handout.***

Name (First, M, Last): _____ Birth Date: _____ Gender: ☐ Female ☐ Male

Social Security Number: _____

Please enroll in ☐ Medical

If you are currently being covered as a dependent under another CalPERS sponsored health plan, you and/or your family members cannot also be covered under the CSU health plan.

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. Is your Spouse/DP currently on a medical plan through a CalPERS/State agency? ☐ No ☐ Yes

   If yes, please list the agency your spouse is working for: _____

2. If yes, are you/your dependent(s) currently enrolled in your Spouse's/DP's plan? ☐ No ☐ Yes

3. Are you and your dependent(s) being deleted from this coverage? ☐ No ☐ Yes, Effective Date _____

DEPENDENTS (Children under the age of 26 years)

A copy of the birth certificate and Social Security Number is required when enrolling dependent children

Family Relationship	Legal Name (First, M, Last)	DOB (mm/dd/yy)	Social Security Number	Gender (M/F)	Health Add Delete
					◯ ◯
					◯ ◯
					◯ ◯
					◯ ◯
					◯ ◯

☐ I elect to **ENROLL or CHANGE** to the Health Benefits Plan as shown on page 1 and authorize deductions to be made from my salary to cover my share of the monthly premium as it is now or as it may be in the future. I also certify that the names of all the dependents listed above are eligible family members as defined in the Public Employees' Medical and Hospital Care Act

☐ I elect to **CANCEL** my Health Benefits Plan as shown on page 1

☐ I **DO NOT** wish to enroll in the Health Benefits Plan under the Public Employees' Medical and Hospital Care Act

_____ _____

Signature **Date**