BENEFITS ENROLLMENT/CHANGE WORKSHEET

This worksheet is needed to initiate enrollment or make changes to your health benefits. This form must be received in Human Resources within 60 days from your appointment date or qualifying event date.

First Name	M.I.	Last Name	Employee Social Security Number

Mailing Address	City	State	Zip

Date of Birth	Spouse/Domestic Partner Name	Spouse/Domestic Partner DOB	Date Hired	Work Phone

Qualifying Event Date:	Date Married	Home Phone/Cell Phone

Sex	Employed as:	Marital Status	Spouse's/Domestic Partner's Social Security Number
☐ Male ☐ Female	☐ Faculty ☐ Staff ☐ Management	☐ Single ☐ Married ☐ Domestic Partnership	

ACTION TO BE TAKEN:				Comments:
☐	New Enrollment	☐	Open Enrollment	
☐	Cancel Coverage (explain)	☐	Decline Coverage (explain)	
☐	Ineligible Dependent	☐	Death	
☐	Birth/Adoption (proper documentation required)	☐	Other	
☐	Marriage or Divorce (proper documentation required)			

HEALTH PLAN:		Health Maintenance Organization (HMO)		Preferred Provider Organization (PPO)
	☐	Anthem Blue Cross Traditional	☐	PERSCare
	☐	Anthem Blue Cross Select	☐	PERS Choice
	☐	Blue Shield Access+ California	☐	PERS Select California
	☐	Blue Shield Net Value		
	☐	Kaiser Permanente California		**HMO**
	☐	Peace Officers Research Association of CA (PORAC	☐	UnitedHealthCare Alliance HMO CA

DENTAL PLANS:	☐	Delta Dental PPO	☐	DeltaCare USA :______________________________ *If you are enrolling in Delta Care USA, please provide name of dentist and provider number.*

FLEXCASH:*

☐	Enroll In FlexCash in lieu of Health and Dental Insurance. Monthly reimbursement is $140.00
☐	Enroll In FlexCash in lieu of Health Insurance. Monthly reimbursement is $128.
☐	Enroll In FlexCash in lieu of Dental Insurance. Monthly reimbursement is $12.00

Please provide Name, Policy or Group Number of alternate Health and Dental insurance

Name of Health Plan	Policy or Group Number	Name of Dental Plan	Policy or Group Number

**** If alternate insurance is provided through your spouse or domestic partner, please provide their social security number.***

Name (First, MI, Last)	Relationship	Social Security Number	DOB (mm/dd/yy)	M/F	Health	Dental	Add	Delete
	Self				☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

I elect to enroll in (or make changes to) the plans shown above and authorize deductions to be made from my salary to cover my share of the cost of enrollment as it is now or may be in the future.

____ ________________

Employee Signature **Date**

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The following documentation is required, in addition to a completed Benefits Enrollment Form, for any eligible employee and/or their dependents. Copies of documents will suffice, we do not need originals.

REQUIRED ELIGIBILITY DOCUMENTATION

	Benefit Enrollment Form	Marriage Certificate	Domestic Partnership State Reg.	Birth Certificate	Adoption Certificate	Court Order	Proof of Other Coverage (Health or Dental)
Employee	▪						
Spouse	▪	▪					
Domestic Partner	▪		▪				
Child: Natural	▪			▪			
Child: Step-Child	▪			▪			
Child: Domestic Partner	▪		▪	▪			
Child: Adopted	▪				▪		
Child: Legal Guardianship	▪					▪	
Child: Court Order	▪					▪	