CAL MARITIME

BENEFITS ENROLLMENT/CHANGE WORKSHEET

PLEASE COMPLETE AND SUBMIT THIS FORM TO THE DEPARTMENT OF HUMAN RESOURCES.

TYPE OF ACTION

☐ Enroll in a Plan(s) ☐ Add/Delete Dependents ☐ Change Plan(s) ☐ Cancel Plan(s) ☐ Decline All Plans

Permitting Event: Select One Permitting Event 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 and Dental Coverage):

☐ 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 following **dental** plan:

- ☐ Delta Dental (PPO) ☐ Delta Care USA (HMO)

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

If electing FlexCash, you must provide proof of coverage. Complete the following:

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

Medical Insurance Company: _____Group Number: _____

Dental Insurance Company: _____Group Number: _____

Is your spouse currently employed by a CSU? ☐ No ☐ Yes, CSU: _____

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 (medical or dental).

☐ 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 ☐ Dental ☐ Vision (Changes to VSP Premier Plan enrollment must be done by the employee with VSP.)

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

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. Is your Spouse/DP currently on a medical/dental 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	Health Delete	Dental Add	Dental Delete	Vision Add	Vision Delete
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐

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

☐ 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**

HR Use Only:

Received by: _____ *CalPERS Sent Date:* _____

Processed by: _____ *SCO Sent Date:* _____

HBE Audit: (HR Use Only)

Eff Date: _____ ***CalPERS Health*** ☐

Eff PP: _____ ***SCO: ACAS*** ☐

H ☐ *D* ☐ *V* ☐ *L* ☐ *LTD* ☐

VSP Premier elect ☐ ***VSP Premier*** ☐

Form Rev: Sept 2021 KB