

CSUB FOUNDATION
BENEFITS ENROLLMENT WORKSHEET

1. TYPE OF ACTION 2. SOCIAL SECURITY NUMBER: _____ 3. Married: Yes
 NEW Enrollment No
 CHANGE of coverage 3a. Spouse's Social Security # if
 CANCEL all coverage not adding as dependent) _____

4. Name: _____ Home Phone: _____ Campus Ext: _____

5. Name of Health Plan 6. Name of Dental Plan
 Current: _____ New: _____ Current: _____ New: _____

7. 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: _____

Forwarding address of family member deleted: _____

SSN	FAMILY MEMBERS	BIRTHDATE	RELATIONSHIP	ADD/ DELETE	PRIMARY PHYSICIAN/ FACILITY
n/a			Self		

It is understood that Foundation procedures prohibit the staff of the Human Resources Office from making value judgements 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 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 CalPERS Board of Administration 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 correctly.

You have 60 days from the date of the eligible appointment to enroll in a health and dental plan. Medical and Dental effective dates will be the first of the month following the date of active employee turns in this worksheet.

Agency Use Only

ACES Batch #

Signature Date