CS – Campus Solutions/Student Info

Benefits Worksheet | Communications

Benefits Worksheet

Submitted Submission Date 09/20/2021

Review Status Completed

THE FOLLOWING INFORMATION IS REQUIRED TO COMPLETE ANY TRANSACTION(S) AFFECTING MEDICAL, DENTAL, VISION, FLEXCASH COVERAGE AND/OR FLEXIBLE SPENDING ACCOUNTS. PLEASE REVIEW THE USER GUIDE IF YOU HAVE QUESTIONS ABOUT COMPLETING THIS FORM. IN ADDITION, PLEASE NOTE THAT IF YOU CLICK ON ANY OF THE LINKS, A NEW INTERNET WINDOW/TAB WILL OPEN UP. TO PROCEED WITH THE WORKSHEET, PLEASE GO BACK TO THE BENEFITS WORKSHEET TAB.

- TO UPDATE YOUR PERSONAL INFORMATION, PLEASE CONTACT HUMAN RESOURCES AT HumanResourcesDepartment@csusb.edu.
- TO UPDATE YOUR PHYSICAL (HOME) ADDRESS, PLEASE VISIT *MYCOYOTE > MY PERSONAL INFORMATION > HOME AND MAILING ADDRESS > EDIT.

I. EMPLOYEE INFORMATION

Empl ID 0000000000 **Legal Name** M Mouse Refresh

Date of Birth 12/31/0000 **Gender** Female

Marital Status Single **Contact Information** E-mail mmouse@csusb.edu

Home Address 1234 Disneyland Dr **City** Anaheim **State** CA **Zip** 12345

Mailing Address 1234 Disneyland Dr **City** Anaheim **State** CA **Zip** 12345

Division C0000 Academic Affairs **Department** CS1630 Enrollment Management - Financial Aid Administration

Unit 091 Analyst **Union Code** R07 Academic Professionals of Cal

Enrollment Type Open Enrollment **Date of Hire**

FOR NEW ENROLLMENTS, PROCEED TO SECTION III TO CONTINUE.

FOR CHANGE OF ENROLLMENT AND OPEN ENROLLMENT, PROCEED TO SECTION II TO CONTINUE.

IF YOU ARE ONLY ENROLLING IN A FLEXIBLE SPENDING ACCOUNT (HCRA/DCRA) COMPLETE AS FOLLOWS:

- SELECT "OPEN ENROLLMENT" AND PROCEED TO SECTION II
- **SECTION II:** ELECT "HCRA/DCRA" UNDER CHANGE OR ENROLL IN A PLAN
- **SECTION III:** CHECK ACCOUNT TYPE AND ENTER MONTHLY AMOUNT
- **SECTION IV:** SELECT "N/A" IN EITHER HMO OR PPO
- **SECTION V:** SELECT "N/A" IN DENTAL PLAN
- **SECTION VII** (Complete only the following):
  - **SELECT** "N/A" IN THE FIRST DROP-DOWN BOX
  - **SELECT** *DOCUMENT TYPE = "DCRA_HCRA FORM" AND UPLOAD DOCUMENT
- **SECTION VIII**:
  - FIRST OPTION- SELECT IF YOU **ARE** ENROLLED IN A HEALTH PLAN THROUGH CSU
  - SECOND OPTION- SELECT IF YOU **ARE NOT** ENROLLED IN A HEALTH PLAN THROUGH CSU
  - COMPLETE NAME, DATE, AND SUBMIT

Kindly note, for HCRA/DCRA only enrollments, follow each section as listed to the left of this note (see bullet points).

Open Enrollment? Skip the below section (you should not be able to select anything in this area)

Are you transferring from a CalPERS/State Agency? **If yes, please list the Agency**

Are you working at another CalPERS or State/Public Agency? **If yes, please list the Agency**

Are you a CalPERS Retiree? (CalPERS Retirees are not eligible for benefits. Please contact HR Benefits for more information.)

II. TRANSACTION INFORMATION

PLEASE SELECT THE ADDITION EVENT OR DELETION EVENT THAT APPLIES TO YOUR TRANSACTION TYPE. ALL TRANSACTIONS REQUIRE SUPPORTING DOCUMENTS AND CANNOT BE PROCESSED WITHOUT THEM. PLEASE REFER TO THE USER GUIDE FOR REQUIRED DOCUMENTS.

**IF YOU ARE ONLY ENROLLING IN A FLEXIBLE SPENDING ACCOUNT (DCRA/HCRA), SELECT "HCRA/DCRA" UNDER CHANGE OR ENROLL IN A PLAN. CONTINUE TO SECTION III.

Change or Enroll in a Plan	Cancel Plan	Add/Delete Dependent
1	1	1

Addition Events	
Event	Event Date

Deletion Events	
Event	Event Date

*Please list former spouse's/Domestic Partner's address:

II.
Tell us what you are requesting for Open Enrollment.
Examples:

- Are you changing or enrolling in health or/and dental? (click + to add both if needed).
- Do you want to cancel one or more plans? (click + to add rows).
- Are you adding or deleting dependent(s) to plan(s) click + to add rows for multiple deletions.

III. FLEXIBLE SPENDING ACCOUNTS

PLEASE:

1. SELECT THE ACCOUNT BY CHECKING THE APPROPRIATE BOX AND ENTER THE MONTHLY AMOUNT

2. DOWNLOAD THE REQUIRED DCRA/HCRA ENROLLMENT FORM, AVAILABLE ON THE BENEFITS OPEN ENROLLMENT WEB PAGE (OR SEE LINK BELOW)

USE THE FOLLOWING LINKS FOR ADDITIONAL INFORMATION ABOUT HCRA AND DCRA.

☐ **Dependent Care Reimbursement Account -**(DCRA) $ **monthly amount ($20 minimum; $416.66 maximum)**

☐ **Health Care Reimbursement Account -** (HCRA) $ **monthly amount ($20 minimum; $229.16 maximum)**

III.
Are you requesting to enroll in a reimbursement account?
If not, skip this section

IV. MEDICAL PLANS

SELECT ONE (1) HMO OR PPO MEDICAL PLAN. FOR MORE INFORMATION, PLEASE REVIEW THE HEALTH BENEFITS SUMMARY ON OUR WEBSITE.

PLEASE NOTE THAT PERS PLATINUM PPO, PERS GOLD PPO AND UNITED HEALTH CARE HARMONY HMO ARE NOT EFFECTIVE UNTIL JANUARY 1, 2022. THESE PLANS ARE AVAILABLE FOR OPEN ENROLLMENT CHANGES BUT NOT FOR NEW ENROLLMENTS OR BENEFIT CHANGES UNTIL AFTER 12/01/2021.

**IF YOU ARE ONLY ENROLLING IN A FLEXIBLE SPENDING ACCOUNT (DCRA/HCRA), SELECT "HCRA/DCRA" UNDER CHANGE OR ENROLL IN A PLAN. CONTINUE TO SECTION V.

HMO: N/A **PPO:**

IV.
Are you changing your health plan?
If not, place "N/A" in this section and move to the next

V. DENTAL PLANS

SELECT ONE (1) DENTAL PLAN FROM THE DROPDOWN MENU. IF YOU SELECT DELTACARE USA DMO, PLEASE PROVIDE A “PROVIDER NAME” AND “DENTAL PROVIDER ID.” FOR MORE INFORMATION, PLEASE VISIT OUR WEBSITE.

**IF YOU ARE ONLY ENROLLING IN A FLEXIBLE SPENDING ACCOUNT (DCRA/HCRA), SELECT "N/A" IN DENTAL PLAN. CONTINUE TO SECTION VII.

Dental Plan N/A **Provider Name:** **Dental Provider ID**

V.
Are you changing your dental plan?
If not, place "N/A" in this section and move to the next

VI. FLEXCASH ENROLLMENT INFORMATION

IF YOU CURRENTLY HAVE OTHER NON-CSU EMPLOYER SPONSORED GROUP COVERAGE, YOU CAN ELECT TO WAIVE CSU COVERAGE IN EXCHANGE FOR A MONTHLY CASH PAYMENT. FEDERAL/STATE SPONSORED PROGRAMS SUCH AS COVERED CALIFORNIA, INSURANCE MARKETPLACES, TRICARE, MEDICARE, OR MEDI-CAL ARE NOT ELIGIBLE FOR MEDICAL FLEXCASH. PLEASE ATTACH A COPY OF YOUR MEDICAL AND/OR DENTAL CARD(S) AS PROOF OF ALTERNATIVE GROUP COVERAGE. FOR MORE INFORMATION, PLEASE VISIT THE FLEXCASH PROGRAM ON OUR WEBSITE.

FLEXCASH Medical **Coverage Through** **SSN**

Employer Name Offering Coverage

Medical Plan Name **Group Number**

FLEXCASH Dental **Coverage Through** **SSN**

Employer Name Offering Coverage

Dental Plan Name **Group Number**

☐ I have reviewed the FlexCash brochure describing CSU's optional FlexCash Plan. I understand that under IRS Code regulations, my elections are irrevocable during this plan year unless I have an allowable "family status change event" and/or other permitting event(s) as described in IRS regulations and/or the FlexCash brochure.

VI.
Are you enrolling in FlexCash (waiving health an or dental)?
If not, skip this section
"To elect this you must have employer sponsored coverage from outside of CSU; we need proof of outside coverage (effective date, names,plan name)"

VII. SELF/DEPENDENT INFORMATION

IF YOU ARE NOT ADDING/DELETING DEPENDENTS, PLEASE ANSWER "N/A" TO THE QUESTION BELOW AND PROCEED TO SECTION VIII.

IF YOU ARE ADDING/DELETING DEPENDENTS, PLEASE ANSWER THE QUESTION(S) BELOW.

**IF YOU ARE ONLY ENROLLING IN A FLEXIBLE SPENDING ACCOUNT (DCRA/HCRA), complete only the following:

- **SELECT** "N/A" IN THE FIRST DROP-DOWN BOX
- **DO NOT COMPLETE:** NAME, DATE OF BIRTH, RELATIONSHIP, SSN, GENDER, MEDICAL, DENTAL VISION
- **SELECT** *DOCUMENT TYPE = "DCRA_HCRA FORM" AND UPLOAD DOCUMENT
  - Important Note: File type JPG and PDF are preferred
- PROCEED TO SECTION VIII

Is your Spouse/Domestic Partner currently enrolled in a medical/dental plan through a CalPERS/State Agency? N/A

If yes, please list the Agency your Spouse/Domestic Partner is working for:

If yes, are you/your dependents currently enrolled on your Spouse/Domestic Partner's plan?

Are you/your dependent(s) being deleted from this coverage? If yes, list the effective date:

IF YOU ARE ADDING/DELETING DEPENDENTS, PLEASE REVIEW THE DEPENDENT SUPPORTING DOCUMENTATION LISTED BELOW. DEPENDENTS WILL NOT BE ADDED/DELETED WITHOUT THE REQUIRED DOCUMENTATION. IF YOU NEED TO ADD MORE THAN ONE DEPENDENT, PLEASE CLICK ON THE "+" ON THE RIGHT CORNER.

**Important Note: File type JPG and PDF are preferred

VII.
Do not list yourself (employee)!

- **Not adding a spouse?** Answer "N/A" to 1st question is this section. This section can be used if the employee needs to upload documents such as HCRA/DCRA form. Note: Do not list your information, just select "Document Type" and click + to upload document.
- **Adding a spouse?** Answer "yes" or "no" for 1st question, list spouse information and upload documents
- **Adding children?** Answer "N/A" for 1st question, list each dependent and upload their documents

Name Pluto | Date of Birth 01/01/0000 | Relationship Child
SSN 111-22-3333 | Gender Male | Medical Add | Dental Add | Vision Add

Personalize | Find | First 1-3 of 3 Last

	*Document Type	Document Date	Attached File	View
1	Birth Certificate - County Certified	09/20/2021	Pluto BC	View
2	Social Security Card	09/20/2021	Soc.pdf	View
3		09/20/2021		View

Need to upload documents?

- Select your "Document Type" (what are you uploading)
- Click + to find and upload your documents. You will also use the + to add multiple documents. The minus sign will delete the upload or row

Self/Dependent Supporting Documentation Required

Your dependents must meet the eligibility criteria set by CalPERS. Please refer to the CalPERS Health Program Guide for more details.

Self/Dependent Supporting Documentation List

SPOUSE or DOMESTIC PARTNER (ADDING): Marriage Certificate/Declaration of Domestic Partnership. Social Security Card. Proof of Residency.

SPOUSE or DOMESTIC PARTNER (DELETING): Divorce Decree/Termination of Domestic Partnership. Death Certificate. Evidence Of Gaining Alternate Coverage.

CHILDREN: Birth Certificate(s)/Hospital Record (newborns) or Adoption Papers. Social Security Card(s).

DISABLED CHILDREN OVER AGE 26: If you have a disabled child with a Social Security-approved disability, you must provide CalPERS with a copy of his or her Medicare card. In addition, you must submit a Member Questionnaire for the CalPERS Disabled Dependent Benefit form, and your doctor must complete a Medical Report for the CalPERS Disabled Dependent form for CalPERS approval. The documents must be approved by CalPERS prior to enrollment and must be updated upon request.

PARENT-CHILD RELATIONSHIP: Affidavit of Parent-Child Relationship. Birth Certificate.Social Security Card. Recent income tax return or court order naming employee/spouse as legal guardian, and/or daycare receipts/school records indicating residence at employees¿ mailing address. Submit the Affidavit and tax return annually thereafter up to age 26. HR Benefits will approve/deny each affidavit.

SPLIT ENROLLMENTS: When two active or retired members are married to each other or they are in a domestic partnership, each member can enroll separately. However, when these individuals enroll in a CalPERS health plan in their own right, one parent must carry all dependents on one health plan. Parents cannot split enrollment of dependents. CalPERS will retroactively cancel split enrollments. You may be responsible for all costs incurred from the date the split enrollment began.

ENROLLING in TWO CalPERS HEALTH PLANS: Dual CalPERS coverage occurs when you are enrolled in a CalPERS health plan as both a member and a dependent or as a dependent on two enrollments. This duplication of coverage is against the law. When dual CalPERS coverage is discovered, the enrollment that caused the dual coverage will be retroactively canceled. You may be responsible for all costs incurred from the date the dual coverage began. Members may enroll in both a CalPERS health plan and a health plan provided through another non-CalPERS employer. During Open Enrollment, it is your/your dependent's responsibility to submit an Open Enrollment transaction with the appropriate agency to request deletion from the other plan. We are not able to process the enrollment until the cancellation with the other plan has processed.

VIII. ENROLLMENT

PLEASE SELECT ONE OF THE FOLLOWING:

**Note: IF YOU ARE ONLY ENROLLING IN A FLEXIBLE SPENDING ACCOUNT (DCRA/HCRA):

- **FIRST OPTION-** SELECT IF YOU **ARE** ENROLLED IN A HEALTH PLAN THROUGH CSU
- **SECOND OPTION-** SELECT IF YOU **ARE NOT** ENROLLED IN A HEALTH PLAN THROUGH CSU
- COMPLETE NAME, DATE AND SUBMIT

(●) If you are enrolling in a health plan or changing a dependent on your health plan, carefully review the information in this section and check the box:

I ELECT TO ENROLL in (or MAKE CHANGES TO) a CalPERS Health Program as indicated on the previous pages and agree to authorize deductions from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future. I CERTIFY that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. I AGREE to read the associated Evidence of Coverage (EOC) and any subsequent EOC's in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all of the terms and conditions of the
EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any medical malpractice dispute regarding medical services rendered under this contract were unnecessary, unauthorized, improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law. There will not be a lawsuit or court process except as California Law provides for judicial review of arbitration proceedings. By entering into this agreement, the parties are giving up their constitutional right to have any dispute decided in a court of law before a jury and instead they are accepting the use of arbitration.

( ) If you are not enrolling in a health plan or cancelling your health plan, carefully review the information in this section and check the box:

I DECLINE ENROLLMENT into a CalPERS Health Program for myself and/or my dependents.

I UNDERSTAND that if I choose to enroll later, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in a health benefits plan. Furthermore, if my dependents and/or I involuntarily lose other health/dental insurance coverage, I may request enrollment into either Program within 60 days from the date of loss of coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the following month following the 90-day wait period or the OE effective date.

VIII.

- **Are you enrolled in a health plan or enrolling in a health plan?**
  Click on the 1st radio button (even if you made no changes to health)
- **Are you only enrolled in dental and/or vision?**
  Click on the 2nd radio button

Type Employee Name M Mouse **Date** 09/20/2021

- **Sign & Date**

Privacy Information

Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with statuses regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its function regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Service Center at 1-888-CalPERS (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public law 93-579) requires that Federal, State and/or Local Government Agencies to disclose if the Social Security Number is mandatory, voluntary and which statutory or other authority the number is solicited by, and the purpose of such disclosure. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security Numbers for the coordination of Federal and State benefits.

The CalPERS Health Program and CSU Dental Plan uses Social Security Numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contributions for State employees
3. Billing of contracting agencies for employee and employer contributions
4. Reports to CalPERS and other State Agencies
5. Coordination of benefits among health plans
6. Resolution of member complaints, grievances and appeals with health plans

IMPORTANT: It is your responsibility to notify HR Benefits when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, changes of address, marriage, divorce, legal separation and death. Failure to notify HR Benefits may result in adverse consequences.

Benefits Staff Reviewing TAR **Review Status** Submitted

Last Updated By 000000000 Daisy Duck

Date/Time 09/21/21 1:27:11PM

You can either:

- **Click "submit" if you are ready to let us know the changes**
- **Click "save" to return back to the form later to finish or upload documents**

Submit Return Form

Save Return to Search