

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.

Are you employed by or are you trail If yes, which campus(es)?	nsferring from a	nother campus in the C	California S	tate University	system?			Yes	N	lo
First Name	Last Name			Employee ID			Home Pl	none		
Employed as Staff Management	Marital Status		mestic Partr	nership						
ACTIONS TO BE TAKEN:	New enrollm	nent Open enrollr	ment	Changes due	to permitt newborn, a	ing eve	ent* is, mar	riage, d	ivorce)
* Date of Event:	Describe the B	Event:								
HEALTH PLANS: When enrolling in an HMO plan you musselect a Primary Care Physician for yourself and each enrolled dependent. Please call your health plan's Customer Service and provide them this information Anthem Blue Cross Traditional (855-839-4524) Anthem Blue Cross Select HMO California (855-839-4524) Blue Shield Access+ (Advantage (800-334-5847) DENTAL PLANS: Delta If you are enrolling in Delta Care USA, put FLEXCASH:* Enroll In FlexCash in lieu of	Premier PPO	me of dentist and provider ental Insurance. Mon ince. Monthly reimbul	is (San Dieg ince re USA number ithly reimb	Name of DeltaCare	Members Police As: (800-937	ORAC of the Sociatio	PPC Statewin only	PERS (PERS F	Gold Platinu	
		Policy or Group Number of			nsurance					
	olicy or Group Numb				Policy or Group Number					
* If alternate insurance is provided throug domestic partner's, please provide their				omestic Partner's urity Number:	;					
FLEXIBLE SPENDING ACCO	OUNTS (DCF	RA & HCRA):	The amour	nt designated wi	ll be deduc	ted mo	nthly.			
DEPENDENT CARE (DCRA)	Λ	Monthly deduction:		This account is for dependent care related expenses only. The minimum monthly contribution is \$20.00, the maximum monthly contribution is \$416.66.					penses 0.00, the	
HEALTH CARE REIMBURSEMENT	Γ(HCRA) Λ	Nonthly deduction:	\$		This plan is fo The minimum maximum mo	or health monthly	related contrib	expense ution is \$	s only. 20.00,	
Please list all eligible dependent to be e a copy of your marriage certificate. If yo approved declaration of domestic partne their birth certificates. Additional you mu	u are enrolling a ership. If you are	domestic partner, you mus enrolling dependent childre	st porivde a d en, you mus	, you must provid copy of the state t provide a copy of	e of	LTH		NTAL		ION
Name (First M.I. Last)	Birth Date	Relationship	So	cial Security Number	Add	Delete	Add	Delete	Add	Delete



TAX ADVANTAGE PREMIUM PLAN

HCRA DCRA

FlexCash

ACES

At CSUF, all employees who enroll in health insurance benefits may choose whether or not they wish to pay taxes on the portion of their salary that goes to pay their health insurance premium. If you choose to participate in TAPP (Tax Advantage Premium Plan), the money you pay toward your health insurance premiums each month will be excluded from your taxable income.

TAPP allows an employee's health insurance premium to be withheld from his/her pay warrants with no federal or state taxes applied. With TAPP pre-tax premium payments, federal, state, and Social Security taxes will be lower.

Enrollment in this plan is automatic, unless non-participation is specifically designated.

Enrollment in TAPP will not affect your options during the open enrollment period. HOWEVER, during the remainder of the year, TAPP enrollees may only make changes to coverage if a "family status change" occurs. Allowable family status changes are listed in the TAPP brochure. You would not, for example, be able to cancel health coverage (except during open enrollment) due to an increase in premiums.

Some people who have dependent children may be eligible for a **federal income tax credit** for health insurance and, as a result, save more money if they pay for health insurance premiums from <u>after-tax</u> salary (non-TAPP). Please check with the IRS or your tax advisor for specific information.

If you are nearing retirement age, keep in mind that your Social Security benefits at retirement will be affected (reduced) because of your TAPP participation. You will not be paying Social Security taxes on the portion of your salary that goes to health insurance premiums.

Do you wish to parti	cipate in the Tax Adv	/antage Premium Plan (TAI	PP) program?	Yes	No
ENROLLMENT (ERTIFICATION				
to cover my share of the	e current/future cost of ned in the Public Emplo	s plan(s) as indicated on this fo enrollment. I also certify that th byees' Medical and Hospital Ca	ne names of all dep	endents listed above are	eligible
Before you sign this f	orm. please double-c	heck to be sure that you hav	e provided all the	information requested.	Thank yo
Cignoture					
Signature			Date		
Human Resource					
Received Date					
HUMAN RESO	JRCES USE ONL	Y			
CMS Keyed Date	Deduction Paid Pay Period	Comments		Documents on File	
Health				Marriage Certificate	
Dental				Domestic Partnership	
Vision, Life & LTD				Birth Certificate	

Reviewed By:

Date:

Adoption Papers

Divorce Decree

HBD-12A Initial Cobra

Affidavit of Eligibility