CALIFORNIA STATE UNIVERSITY
FULLERTON
Human Resources, Diversity & Inclusion http://hr.fullerton.edu

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 transferring from another campus in the California State University system ? ☐ Yes ☐ No
If yes, which campus(es)? _____

First Name	Last Name	Employee ID	Home Phone

Employed as
☐ Faculty ☐ Staff ☐ Management

Marital Status
☐ Single ☐ Married ☐ Domestic Partnership

ACTIONS TO BE TAKEN:

☐ New enrollment ☐ Open enrollment ☐ Changes due to permitting event*

* Date of Event: _____ Describe the Event: _____ (i.e. newborn, adoptions, marriage, divorce)

HEALTH PLANS:

When enrolling in an HMO plan you must select 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)

Health Maintenance Organization (HMO)

☐ Health Net Salud y Mas (888-926-4921)

☐ Health Net SmartCare (888-926-4921)

☐ Kaiser Permanente (800-464-4000)

☐ Sharp Performance Plus (San Diego County Residents) (855-839-4524)

☐ United HealthCare Alliance (877-359-3714)

Preferred Provider Organization (PPO)

Anthem Blue Cross Plans (877-737-7776)

☐ PersCare
☐ PersChoice
☐ Pers Select

☐ PORAC PPO

Members of the Statewide University Police Association only (800-937-6722)

DENTAL PLANS:

☐ Delta Premier PPO/DPO ☐ DeltaCare USA

Name of DeltaCare USA DENTIST & Provider Number

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 $128.00
☐ 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's or domestic partner's, please provide their social security number*

Spouse's /Domestic Partner's Social Security Number:

FLEXIBLE SPENDING ACCOUNTS (DCRA & HCRA):

The amount designated will be deducted monthly.

DEPENDENT CARE (DCRA) ***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.*

HEALTH CARE REIMBURSEMENT (HCRA) ***Monthly deduction:*** $ _____ *This plan is for health related expenses only. The minimum monthly contribution is $20.00, the maximum monthly contribution amount is $212.50.*

Please list all eligible dependent to be enrolled, including yourself. If you are enrolling a spouse, you must provide a copy of your marriage certificate. If you are enrolling a domestic partner, you must porivde a copy of the state approved declaration of domestic partnership. If you are enrolling dependent children, you must provide a copy of their birth certificates. Additional you must provide the social security numbers of all dependents being enrolled.

				HEALTH		DENTAL		VISION	
Name (First M.I. Last)	Birth Date	Relationship	Social Security Number	Add	Delete	Add	Delete	Add	Delete
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

CALIFORNIA STATE UNIVERSITY
FULLERTON
Human Resources, Diversity & Inclusion http://hr.fullerton.edu

TAX ADVANTAGE PREMIUM PLAN

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 after-tax 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 participate in the Tax Advantage Premium Plan (TAPP) program? ☐ Yes ☐ No

ENROLLMENT CERTIFICATION

I elect to enroll in (or change to) health benefits plan(s) as indicated on this form and I authorize deductions to be made from my salary to cover my share of the current/future cost of enrollment. I also certify that the names of all dependents listed above are eligible family members as defined in the Public Employees' Medical and Hospital Care Act and that they are not enrolled in another CalPers medical plan or State of California dental Plan.

Before you sign this form, please double-check to be sure that you have provided all the information requested. Thank you!

Signature _____ Date _____

Human Resource
Received Date

HUMAN RESOURCES USE ONLY

CMS Keyed Date	Deduction Paid Pay Period	Comments	**Documents on File**	
Health			Marriage Certificate	
Dental			Domestic Partnership	
Vision, Life & LTD			Birth Certificate	
HCRA			Adoption Papers	
DCRA			Divorce Decree	
FlexCash			Affidavit of Eligibility	
ACES			HBD-12A	
			Initial Cobra	
		Reviewed By:	Date:	