CALIFORNIA STATE UNIVERSITY CHANNEL ISLANDS

Health/Dental/HCRA/DCRA Worksheet
(Health Insurance premiums are listed on the reverse side of this worksheet)

(PLEASE RETURN FORM TO HUMAN RESOURCES PROGRAMS, SOLANO HALL, ROOM 1123)

1. Type of Action (Check One)
   - ☐ NEW ENROLLMENT
   - ☐ CHANGE of COVERAGE
     _____
     (List reason: Marriage, Birth of Child, etc.)
   - ☐ CANCEL COVERAGE
   - ☐ OPEN ENROLLMENT
   - ☐ FLEX CASH ☐ Health ☐ Dental

(Proof of coverage is required at time of enrollment, i.e., ins. card.)

New HCRA Enrollment $ _____

New DCRA Enrollment $ _____

2. Permitting Event Date
(Month/Day/Year)

_____

(Examples include: Date of Hire, Date of Marriage, Child's Date of Birth)

Date of Hire

_____

3. (For Benefits Use Only)

Effective Date: _____
(Month/Day/Year)

4. (For Benefits Use Only)

Employee ID No. _____

5. Employee's Name: _____
(First) (MI) (Last)

Mailing Address: _____

City, State, Zip: _____

E-Mail Address: _____

Phone: _____

6. Employee's Social Security No: _____

7. Employee's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner

8. Spouse's/Domestic Partner's Social Security No: _____

9. Name of Health Plan: _____

10. Primary Care Physician/Medical Group:
(Complete for Blue Shield HMO only)

11. Name of Dental Plan: ☐ Delta Dental Premier ☐ Delta Care/PMI PMI Dental Provider _____
City or Office Number _____

12. List all eligible dependents you wish to enroll in medical and/or dental coverage. Please be sure to include yourself.

- To enroll a spouse, you must provide a copy of your marriage certificate/Affidavit of Marriage and spouse's Social Security Number.
- To enroll a Domestic Partner, you must provide your "Declaration of Domestic Partnership" from the Secretary of State and your Domestic Partner's Social Security Number
- To enroll a child who is economically dependent (but is not your natural, adopted, or stepchild), you must complete an Affidavit of Eligibility for the child.
- Relationship descriptions (not all inclusive): Adopted daughter, adopted son, daughter, domestic partner, domestic partner's child, son, spouse, stepdaughter, or stepson.

Action Code A = Add D = Delete	(First) (MI) (Last)	Date of Birth (Month/Day/Yr)	Social Security Number	Relationship	Plan Type (Health/Dental/Both)
A				Self	

I hereby elect to enroll in (or change) a Health and/or Dental Plan as shown in Items 9 and 11 above, and authorize deductions to be made from my salary or retirement allowance 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 names of all dependents listed above in item 12 are eligible.

_____ _____ _____
Employee Signature Date Work Phone