ANNUAL HEALTH PLAN OPEN ENROLLMENT ELECTION FORM

09/16/2024- 10/11/2024

PLEASE COMPLETE & RETURN BY OCTOBER 11, 2024

FULL NAME: _____ **DEPARTMENT:** _____

EMPLOYEE TYPE ***(Please checkmark)*****:**

Classified Employees	Police Officer	Faculty	Management/Confidential	Non-Unit
☐ Part-time (between 20-34 hrs/week) ☐ Full-time (at least 35 hrs/week)	☐ Full-time (at least 35 hrs/week)	☐ Full-time	☐ Academic Administrator ☐ Classified Manager ☐ Confidential	☐ Board of Trustees ☐ Personnel Commissioner ☐ Project Manager

I would like to make the following changes to my coverage and have attached the necessary documents to verify the eligibility of my dependents. I understand that if I elect to change my medical or dental plan/s, I must also include the applicable plan enrollment form/s.

☐ **Change to current HEALTH Coverage.**

- ☐ *New enrollment**
- ☐ *Change to Health Plan (i.e. Kaiser to PERS Choice/ Blue Shield to Kaiser, etc.)*
- ☐ *Cancel enrollment*
- ☐ *Opt-Out of Health coverage*
- ☐ ***Add* Dependent** ☐ ***Delete* Dependent**

	Dependent Name	Date of Birth	Social Security No.
(1)			
(2)			
(3)			
(4)			

☐ **Change to current DENTAL Coverage.**

- ☐ *New enrollment**
- ☐ *Change to Dental Plan (i.e. Delta Care HMO to Delta Dental PPO plan)*
- ☐ *Cancel enrollment*
- ☐ ***Add* Dependent** ☐ ***Delete* Dependent**

	Dependent Name	Date of Birth	Social Security No.
(1)			
(2)			
(3)			
(4)			

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☐ **Change to current VISION Coverage.**

- ☐ *New enrollment**
- ☐ *Cancel enrollment*
- ☐ ***Add* Dependent** ☐ ***Delete* Dependent**

	Dependent Name	Date of Birth	Social Security No.
(1)			
(2)			
(3)			
(4)			

** All dependents and enrollees must meet benefits eligibility requirements and provide proof of eligibility at the time of enrollment (i.e. birth certificates, marriage certificates, certification of domestic partnership, etc).* ***Eligible*** *dependents include: spouse, registered domestic partner, children (natural, adopted, domestic partner's or step) up to age 26 for all plans, including health, dental and vision.*

Not eligible*: Former spouses/former registered domestic partners, children age 26 or older, disabled children over age 26 who were never enrolled or who were deleted from coverage, foster children, children of a former spouse/former registered domestic partner, grandparents and parents.* ***CalPERS requires you to report life changes such as divorce or termination of a domestic partnership in a timely manner. If you fail to report changes, CalPERS may hold you liable for the reimbursement of health premiums or health care service incurred during the entire ineligibility period. (See CalPERS Open Enrollment news publication.)***

SIGNATURE: _____ **DATE SIGNED:** _____