BENEFITS ENROLLMENT/CHANGE WORKSHEET

PLEASE COMPLETE AND SUBMIT THIS FORM TO THE DEPARTMENT OF HUMAN RESOURCES

TYPE OF

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DEPENDENT INFORMATION (Please Print)

Please list all dependents you wish to have covered under the appropriate sections below. Please check the appropriate benefit coverage you are electing for each dependent (medical or dental).

Spouse or Domestic Partner

*If enrolling a spouse, a copy of the marriage certificate is required

**If enrolling a Domestic Partner, a copy of the Declaration of Domestic Partnership is required. Review the Domestic Benefits Tax Implication handout.

Name (First, M, Last): _____Birth Date: _____

Gender: Female Male Nonbinary Social Security Number: _____

Please enroll in Medical Dental Vision (Changes to VSP Premier Plan enrollment must be done by the employee with VSP.)

If you are currently being covered as a dependent under another CalPERS sponsored