Associated Students, Incorporated
California State University, Long Beach

Personal Benefit Statement

Plan Year 2019

Employee Information

Last Name	First Name	Middle Name	Date of Birth MM	DD	YR	Date of Hire MM	DD	YR	Insurance Date MM	DD	YR	Sex
											19	○ M ○ F

Street Address	Apt No.	City	State	Zip	Marital Status
					○ Married ○ Single

Social Security Number	Department	Job Title	

Eligible Dependent Information

You must provide information on your dependents

First Name (& Last if different)	Social Security Number	Birthdate	MEDICAL Do you elect dependent coverage? Please circle	DENTAL	VISION
1. Spouse			○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
2. Child			○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
3. Child			○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
4. Child			○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Medical/Dental/Vision Coverage

Coverage Selection		Employee Coverage		Premium Only Plan	
Medical	HMO	○ Yes	○ No	○ Yes	○ No
	PPO	○ Yes	○ No	○ Yes	○ No
Dental	HMO Delta Care	○ Yes	○ No	○ NA	○ NA
	PPO Delta Dental	○ Yes	○ No	○ NA	○ NA
Vision	Vision Services Plan	○ Yes	○ No	○ Yes	○ No

Beneficiary Designation(s)

Please review your life insurance and retirement beneficiary information each year. You may update and make changes by requesting, completing and filing the correct change form. See Human Resources for more information.

Additional Benefit Coverage

AFLAC	○ Yes	○ No
SRWC Fitness Membership	○ Yes	○ No

Signature

Employee	Date	Comments
		See back for special instructions

Due in Human Resources by: October 31, 2018