49ER FORTY-NINER SHOPS, INC.
CALIFORNIA STATE UNIVERSITY, LONG BEACH
HUMAN RESOURCES DEPARTMENT 562-985-7476

Group Health Insurance
Open Enrollment Change Notification Form

*This form confirms your intent to **maintain or make changes** to your existing healthcare plan(s) for the upcoming Plan Year. Please provide the information below and specify any desired changes. **NOTE: Additional enrollment forms may be required to complete your change request.***

Employee Information (please print)

Last Name	First Name	MI	Last 4 SSN	Marital Status	DOB
					/ /

Address	City	State	Zip	Phone & Email

No Change: ☐ I do ***not*** wish to make any changes to my existing medical, dental, and/or vision plan coverage(s) for the upcoming Plan Year.

Change(s): ☐ I wish to ***make the following change(s)*** to my existing plan coverage(s) as indicated below.

☐ **Medical**	☐ ***Add*** Coverage Carrier Name: Type: ☐ HMO ☐ PPO	☐ ***Delete*** Coverage Carrier Name: Type: ☐ HMO ☐ PPO	**Dependent(s)** ☐ ***Add*** ☐ ***Delete***
☐ **Delta Dental PPO**	☐ ***Add*** Coverage	☐ ***Delete*** Coverage	**Dependent(s)** ☐ ***Add*** ☐ ***Delete***
☐ **Delta Dental HMO**	☐ ***Add*** Coverage	☐ ***Delete*** Coverage	**Dependent(s)** ☐ ***Add*** ☐ ***Delete***
☐ **Vision**	☐ ***Add*** Coverage	☐ ***Delete*** Coverage	**Dependent(s)** ☐ ***Add*** ☐ ***Delete***

*Current Participants in the **Employee Benefits Waiver Program** and* the ***Flex Savings Benefits Program*** are ***required to re-enroll*** for each new Plan Year.

Employee's Signature	*Date Signed*

HUMAN RESOURCES OFFICE USE ONLY

Effective Date:	*Action(s):*	*HR Initials*