



California Public Employees' Retirement System
P.O. Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN

ENROLLMENT FORM

PERS-HBD-12 (Rev.8/10)

**DO NOT SEND MEDICAL
CLAIMS TO THIS ADDRESS**

CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER

PLEASE TYPE

| | | | | | | | |
|---|--|--|---|------------------|-----------------------------|---------------------------------------|------------------|
| 1. TYPE OF ACTION (Check One) | 2. SOCIAL SECURITY NUMBER ____ | A C C O U N T I D E N | LIST ALL PERSONS (including self) TO BE ENROLLED IN: | DATE OF BIRTH | Family Relation- ship | G E N D E R M F | C O D E |
| <input type="checkbox"/> a. NEW enrollment <input type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage | 3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER ____ | | 17. BASIC PLAN | Mo. Day Yr. | | | |
| | | | (FIRST) (MI) (LAST) | | SELF | | |
| 4A. Name | | | SSN | | | | |
| Mailing Address | (FIRST) (MI) (LAST) | | (FIRST) (MI) (LAST) | | | | |
| City, State, ZIP | Daytime Phone | Evening Phone | SSN | | | | |
| 4B. RESIDENCE ZIP CODE (If different from 4A) | | | (FIRST) (MI) (LAST) | | | | |
| 5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only) | 6. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female | 7. MARRIED <input type="checkbox"/> Yes <input type="checkbox"/> No | SSN | | | | |
| | | | (FIRST) (MI) (LAST) | | | | |
| 8. PLAN CODE | 9. NAME OF HEALTH PLAN | | SSN | | | | |
| 10. GROSS PREMIUM \$ | 11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP | | | | | | |
| 12. PRIOR PLAN CODE | 13. PRIOR HEALTH PLAN | A C C O U N T I D E N | 18. SUPPLEMENTAL PLAN | DATE OF BIRTH | Relation- ship | | C O D E |
| | | | (FIRST) (MI) (LAST) | Mo. Day Yr. | | | |
| 14. Reason Code | 15. Permitting Event Date Mo. Day Yr. | | 16. EFFECTIVE DATE Mo. Day Yr. | | | | |

19. CHECK ONE

- ☐ I **DO NOT** elect to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 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 also certify that the names of all dependents listed above in items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in items 12 and 13 above.

| | |
|---|---------------------------------|
| 20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy) | 21. DATE SIGNED Mo. Day Year |
| TELEPHONE NUMBER () | |

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

| | | | | | |
|--|--|------------------------------|----------------|-----------------------------|---------------------|
| 22. DEDUCTION PLAN CODE | 23. Type of action (Check One) 1. <input type="checkbox"/> New 2. <input type="checkbox"/> Cancel 3. <input type="checkbox"/> Change | 24. PAY PERIOD Month Year | 25. PARTY CODE | 26. EMPLOYEE DESIGNATION | 27. BARGAINING UNIT |
| 28. AGENCY NAME (or Retirement System) | 29. PAYROLL OFFICE CODE | 30. AGENCY CODE | 31. UNIT CODE | | |

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

SIGNATURE OF HEALTH BENEFITS OFFICER

Mo. Day Year

35. REMARKS

____ of ____ Forms
WHITE - HB PINK - Agency BLUE - Employee

33. Date received in
employing office

Mo. Day Year

34. PHONE NUMBER

()

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another governmental agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, PERS, P.O. Box 942714, Sacramento, CA 94229-2714.

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and state benefits. Furthermore, the Office of Employer and Member Health Services requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits. Specifically, the California Public Employees' Retirement System uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Payroll deduction and state contribution for state employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to the Public Employees' Retirement System and other state agencies.
5. Coordination of benefits among carriers.

BINDING ARBITRATION

Enrollment in certain plans constitutes an agreement to have any issue of medical malpractice decided by neutral arbitration and waiver of any right to a jury or court trial. Refer to the health plan Evidence of Coverage booklet to determine if this provision is applicable to your plan.