

Health Benefit Plan Enrollment Form Guide

Please fill out form on your computer

If you are an *EMPLOYEE*,

Fill out all of the **YELLOW** sections (as shown on the next page.)

Leave the **PINK** sections blank.

Print the form.

Sign section 20.

Bring the form to your payroll coordinator.

The *PAYROLL COORDINATOR* will fill out the **PINK sections.**

Employees enrolling dependents must provide:

- Social security number
- Copies of marriage certificate or domestic partner registration and birth certificates
- The County cannot process any changes or additions without dependent documentation on file



California Public Employees' Retirement System
 P.O. Box 942715
 Sacramento, CA 94229-2715

Employee Personnel Number

HEALTH BENEFIT PLAN
 ENROLLMENT FORM **DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS**
 PERS-HBD-12 (Rev. 6/13)

CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER

PLEASE TYPE

1. TYPE OF ACTION (Check One)		2. SOCIAL SECURITY NUMBER		LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH			Family Relationship	GENDER	CODE			
<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)						
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		7. MARRIED		SSN							
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		(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		18. SUPPLEMENTAL PLAN		DATE OF BIRTH			Relationship	CODE			
				(FIRST)	(MI)	(LAST)	Mo.	Day			Yr.		
14. Reason Code		15. Permitting Event Date		16. EFFECTIVE DATE									
		Mo.	Day	Yr.	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

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	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
			Month Year			

28. AGENCY NAME (or Retirement System)	29. PAYROLL OFFICE CODE	30. AGENCY CODE	31. UNIT CODE
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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.	SIGNATURE OF HEALTH BENEFITS OFFICER	33. Date received in employing office		
		Mo.	Day	Year

34. PHONE NUMBER

35. REMARKS

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

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, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

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, Health Account 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.



Office of Employer and Member Health Services
 PO Box 942714
 Sacramento, CA 94229-2714
 Toll Free: (888) CalPERS (225-7377) Fax: (916) 795-1313
 Telecommunications Device for the Deaf: (916) 795-3240

Declaration of Health Coverage: HBD-12A

(INSTRUCTIONS ON REVERSE)

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME (FIRST)	(MIDDLE)	(LAST)
PART A <input type="checkbox"/> I elect to enroll myself and all eligible dependents.			
PART B-1 <input type="checkbox"/> I elect to enroll myself. My eligible dependents have other health insurance coverage.		<p>If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage.</p> <p>If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.</p>	
PART B-2 <input type="checkbox"/> I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage.			
PART C-1 <input type="checkbox"/> I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.			
PART C-2 <input type="checkbox"/> I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.		<p>You can request enrollment for yourself and/or your dependents at any time. You must wait at least 90 days after you request enrollment or until the next Open Enrollment period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.</p>	

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependents, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependents, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

Member's Signature

Date Signed

Health Benefits Officer's Signature

Rev (3/09)

Original: Employee's Personnel File

Copy: Employee

INSTRUCTIONS - DECLARATION OF HEALTH COVERAGE (HB-12A)

<i>Please contact your Health Benefits Officer if you have any questions regarding the HB-12A</i>	
Employee Information	Complete with the appropriate employee information.
PART A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
PART B-1:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage.
PART B-2:	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
PART C-1:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
PART C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

Special rules for retirement and death:

Consider these points as you decided whether to enroll, decline, or cancel enrollment for yourself or dependents.

- If you are not eligible to be enrolled in a CalPERS-sponsored health plan on the date you separate employment, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are enrolled on your CalPERS-sponsored health plan at this time, they may be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.