CalPERS

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

HEALTH BENEFIT PLAN
ENROLLMENT FORM
PERS-HBD-12 (Rev. 6/13)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

CalPERS **USE ONLY - DOCUMENT REFERENCE NUMBER**

PLEASE TYPE

1. TYPE OF ACTION (Check One)
- ☐ a. NEW enrollment
- ☐ b. CHANGE of coverage
- ☐ c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER — —

3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER — —

4A. Name / Mailing Address (FIRST) (MI) (LAST)

City, State, ZIP | Daytime Phone | Evening Phone

4B. RESIDENCE ZIP CODE (If different from 4A)

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

6. GENDER ☐ Male ☐ Female

7. MARRIED ☐ Yes ☐ No

8. PLAN CODE

9. NAME OF HEALTH PLAN

10. GROSS PREMIUM $

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

14. Reason Code

15. Permitting Event Date: Mo. Day Yr.

16. EFFECTIVE DATE: Mo. Day 01 Yr.

ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN: 17. BASIC PLAN	DATE OF BIRTH Mo.	Day	Yr.	Family Relation-ship	GENDER M	F	CODE
	(FIRST) (MI) (LAST)				SELF			
	SSN							
	(FIRST) (MI) (LAST)							
	SSN							
	(FIRST) (MI) (LAST)							
	SSN							
	(FIRST) (MI) (LAST)							
	SSN							

ACTION CODE	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Relation-ship			CODE

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)

TELEPHONE NUMBER (   )

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. ☐ New 2. ☐ Cancel 3. ☐ 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.

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