



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

Phone #: \_\_\_\_\_

E-Mail: \_\_\_\_\_

HEALTH BENEFITS PLAN  
 ENROLLMENT FORM  
 PERS-HBD 12 (Rev 8/02)

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

CalPERS USE ONLY – DOCUMENT REFERENCE NUMBER

**▶ PLEASE TYPE ◀**

1. TYPE OF ACTION (Check One)  <input type="checkbox"/> a. NEW enrollment <input type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage	2. SOCIAL SECURITY NUMBER  _____	A C C O D E N	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH			Family Relation ship	C O D E	
	3. SPOUSE'S SOCIAL SECURITY NUMBER  _____		17. BASIC PLAN (First) (MI) (LAST)	MO.	DAY	Yr.	SELF		
4a.									
Name (First) (MI) (LAST)									
Mailing Address									
City, State, ZIP									
4B RESIDENCE ZIP CODE (If different from 4A)									
5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only)	6. SEX  <input type="checkbox"/> Male <input type="checkbox"/> Female	7. MARRIED  <input type="checkbox"/> Yes <input type="checkbox"/> 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		A C C O D E N	18. SUPPLEMENTAL PLAN (First) (MI) (LAST)	DATE OF BIRTH			Family Relation ship	C O D E
14. Permitting Event Code	15. Permitting Event Date Mo. Day Yr.	16. EFFECTIVE DATE Mo. Day Yr.		Mo.	Day	Yr.			

19. CHECK ONE  
 I DO NOT wish 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 select 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 1. <input type="checkbox"/> New 2. <input type="checkbox"/> Cancel 3. <input type="checkbox"/> Change  (Check) (One)	24. PAY PERIOD Month Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
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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:  
 SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in employing office  
 Mo. Day Year

34. PHONE NUMBER ( )

35. REMARKS  
 \_\_\_\_\_ of \_\_\_\_\_ Forms

WHITE – HBD PINK – Agency BLUE – Employee

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 22825-22832 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made the Board of Administration, California Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

## **PRIVACY INFORMATION**

Submission of the requested information is mandatory. The information requested is collected pursuant to the 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, PO 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.

The Office of Employer and Member Health Services of the California Public Employees' Retirement System request each enrollee's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other agencies for identification purposes, the Office of Employer and Member Health Services may be unable to verify eligibility for benefits without the Social Security account number.

The Office of Employer and Member Health Services of the California Public Employees' Retirement System uses Social Security account 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 California Public Employees' Retirement System and other state agencies
5. Coordination of benefits among carriers

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## **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 HBD-DO-29 or HBD-DO-22 to determine if this provision is applicable to your plan.