Instructions for Completing
"Health Benefits Plan Enrollment Form - HBD12"

Items 1 - 4
Enter "x" in appropriate box and fill in requested information including social security, address, and phone number.

Item 4B
If you live outside Los Angeles Area Region and select a health plan based on your home address, you may be charged a higher premium (see rate sheet for "Other Southern California Area Regions"). You may elect to use the CVUHSD District Office zip code "90260" as eligibility to select a health plan in the Los Angeles Area

Item 5
Skip this item

Items 6 and 7
Enter "x" in appropriate box. When enrolling spouse, a copy of the Marriage Certificate and the Spouse's Social Security Number are required. When enrolling a domestic partner, a Declaration of Domestic Partnership and the partner's Social Security Number are required.

Item 8
Refer to the Monthly Health Insurance Premiums Chart provided by the District. List the 4 digit Plan Code applicable to the plan you choose. (example: 3062)

Item 9
Refer to the Monthly Health Insurance Premiums Chart provided by the District. List the name of the Health Plan (example: Kaiser)

Item 10
Refer to the Monthly Health Insurance Premiums Chart provided by the District. List the Gross Premium located under Column A. (example: $826.34)

Item 11
Enter the Primary Care Physician and Medical Group name. To select a Physician, you can go online or you may request a copy of the physician directory from Human Resources. If you select HMO but do not designate a Physician/Medical Group, the plan will select one for you.

Blue Shield: www.blueshieldca.com/findaprovider (Choose "Find a Doctor, under Choose a Plan select "CalPERS>>")
Kaiser: www.kaiserpermanente.org/ca/calpers/
Preferred Providers (PPO's): www.anthem.com/ca/calpers/

Item 12 and 13
Enter this information only if you are changing plans or cancelling coverage

Item 14
Skip this item

Item 15
Enter Hire Date

Item 16
Enter 1st of the month following the date you submit enrollment form

Item 17
Enter your name, birthday, gender, and social security #, and include any eligible family members you wish to enroll

Item 18
Skip this item

Item 19
Enter "x" in appropriate box

Items 20 and 21
Signature, telephone number, and date form completed

Items 22 - 35
Skip these items

Return completed form to Human Resources

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)
- ☐ 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:	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	GENDER M	F	CODE
	17. BASIC PLAN							
	(FIRST) (MI) (LAST)				SELF			
	SSN							
	(FIRST) (MI) (LAST)							
	SSN							
	(FIRST) (MI) (LAST)							
	SSN							
	18. SUPPLEMENTAL PLAN	DATE OF BIRTH Mo.	Day	Yr.	Relationship			CODE
	(FIRST) (MI) (LAST)							

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 and the regulations implementing the 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 Government Code Sections (2000, 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 942702, 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.

The Office of Employer and Member Health Services of the California Public Employees' Retirement System requests 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 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 HBD-DO-29 or HBD-DO-22 to determine if this provision is applicable to your plan.