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

# HEALTH BENEFIT PLAN ENROLLMENT FORM

PERS-HBD-12 (Rev. 08/10)

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

Please complete highlighted areas.

Only use this form if you are only changing plans for Open Enrollment. Any other Open Enrollment changes should be made using the Benefit Enrollment Worksheet.

You cannot add or delete dependents using this form.

CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER

**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 First Name, MI, Last Name

Daytime 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: 400

15. Permitting Event Date: 9/12/2016

16. EFFECTIVE DATE: 1/1/2017

| ACTION CODE | LIST ALL PERSONS (including self) TO BE ENROLLED IN: | DATE OF BIRTH | FAMILY RELATIONSHIP | GENDER M | GENDER F | CODE |
|---|---|---|---|---|---|---|
| | **17.** BASIC PLAN | mm/dd/yy | | M | F | |
| | First, MI, Last | | Self | | | |
| | First, MI, Last | | | | | |
| | SSN | | | | | |
| | First, MI, Last | | | | | |
| | SSN | | | | | |
| | First, MI, Last | | | | | |
| | SSN | | | | | |
| | First, MI, Last | | | | | |
| | SSN | | | | | |
| | First, MI, Last | | | | | |
| | SSN | | | | | |
| | **18.** SUPPLEMENTAL PLAN | DATE OF BIRTH | RELATIONSHIP | GENDER | | |
| | 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 show in items 12 and 13 above.

20 EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy) | Employee ID # | Campus Phone | **21.** DATE SIGNED

22. DEDUCTION PLAN CODE

23. TYPE OF ACTION (Check One) ☐ 1. New ☐ 2. Cancel ☒ 3. Change

24. PAY PERIOD: 12/2016

25. PARTY CODE

26. EMPLOYEE DESIGNATION

27. BARGAINING UNIT

28. AGENCY NAME (or Retirement System): Humboldt State University

29. PAYROLL OFFICE CODE

30. AGENCY CODE: 225

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: *Ariel Aaron*

33. Date received in employing office: 9/12/2016

34. PHONE NUMBER: (707) 826-5171

35. REMARKS: Open Enrollment: Plan Change

## 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.

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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 health plan Evidence of Coverage booklet to determine if this provision is applicable to your plan.