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

NOTE: YOUR ADDRESS ON FILE WITH THE HUMAN RESOURCES DEPARTMENT WILL BE USED FOR ALL TRANSACTIONS.

IF YOU ARE ADDING DEPENDENTS AND THIS IS YOUR INITIAL ENROLLMENT, YOU MUST COMPLETE SSNs AND DOBs FOR EACH DEPENDENT AND ATTACH VERIFICATION DOCUMENTATION.

IF YOU ARE ADDING DEPENDENT AND YOU ARE CURRENTLY ENROLLED IN BENEFITS, YOU HAVE 60 DAYS TO SUBMIT VERIFICATION DOCUMENTATION.

MEDICAL PLAN INFORMATION

1. **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**

4. **NAME** (FIRST) (MI) (LAST)

5. **MARRIED** ☐ Yes ☐ No

5a **IF YES, DATE OF MARRIAGE:** Mo. Day Yr.

6. **SELECT A MEDICAL PLAN**
☐ PERS CHOICE PPO
☐ PERS SELECT PPO
☐ PERS CARE PPO
☐ KAISER OF CALIFORNIA
☐ BLUE SHIELD ACCESS+ HMO
☐ ANTHEM SELECT HMO
☐ ANTHEM TRADITIONAL HMO
☐ UNITED HEALTHCARE HMO
☐ HEALTH NET SALUD Y MAS HMO
☐ HEALTH NET SMART CARE HMO

7. **HMO MEDICAL GROUP**

8. **HMO PRIMARY PHYSICIAN**

9. **SELECT A DENTAL PLAN**
(All enrolled participants will receive Dental/Vision)
☐ **DELTA DENTAL PPO**
☐ **DELTA DENTAL HMO (COMPLETE SECTION BELOW)**
DENTAL FACILITY NAME
FACILITY NUMBER
☑ **VISION SERVICE PLAN (VSP)**

10. **PERMITTING EVENT**

11. **EFFECTIVE DATE** Mo. Day Yr.

D = DROP A = ADD	LIST ALL PERSONS TO BE ENROLLED IN MEDICAL, DENTAL, AND VISION.	DATE OF BIRTH	Family Relation-ship	GENDER M	GENDER F	DISABLED
	(FIRST) (MI) (LAST)		SELF	☐	☐	☐
	SOCIAL SECURITY NUMBER	Mo. Day Yr.				
	(FIRST) (MI) (LAST)		-	☐	☐	☐
	SOCIAL SECURITY NUMBER	Mo. Day Yr.				
-	(FIRST) (MI) (LAST)		-	☐	☐	☐
	SOCIAL SECURITY NUMBER	Mo. Day Yr.				
-	(FIRST) (MI) (LAST)		-	☐	☐	☐
	SOCIAL SECURITY NUMBER	Mo. Day Yr.				
-	(FIRST) (MI) (LAST)		-	☐	☐	☐
	SOCIAL SECURITY NUMBER	Mo. Day Yr.				
-	(FIRST) (MI) (LAST)		-	☐	☐	☐
	SOCIAL SECURITY NUMBER	Mo. Day Yr.				

12. **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.

ALL HEALTH BENEFIT PAYROLL CONTRIBUTIONS ARE MADE ON A PRE-TAX BASIS. CHECK THIS BOX ONLY IF YOU **DO NOT** WANT YOUR CONTRIBTIONS TO BE ON A PRE-TAX BASIS ☐

13. **EMPLOYEE OR ANNUITANT'S SIGNATURE** (see privacy information on reverse of employee copy)

14. DATE SIGNED Mo. Day Yr.

☐ CalPERS
☐ CalSTRS

BARGAINING UNIT CODE ____________

SIGNATURE OF HEALTH BENEFITS OFFICER

DATE

ORANGE UNIFIED SCHOOL DISTRICT
1401 NORTH HANDY STREET
ORANGE, CA 92867

I hereby certify under penalty of perjury as follows:
That I am a duly appointed, qualified and acting officer of the 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.

Marriage Cert: _______
Birth Certificate: _____
Tech Initials: ________

Effective Date: ________________________
CalPERS: ___________QSS:___________
D-HMO:___________D-PPO: ___________
Activity Mo.: ___________PR:___________

Class:_____ Ldr:_____ Cert:_____

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).