



Public Employees' Retirement System  
 Post Office Box 942714  
 Sacramento, CA 94229-2714  
**DO NOT SEND MEDICAL  
 CLAIMS TO THIS ADDRESS**

**WORKSHEET. PLEASE COMPLETE ALL CIRCLED AREAS.**

**HEALTH BENEFIT PLAN  
 ENROLLMENT FORM**  
 PERS-HBD-12 (Rev. 10/93)

**PERS USE ONLY—DOCUMENT REFERENCE NUMBER**

▶ **PLEASE TYPE** ◀

<b>1. TYPE OF ACTION</b> (Check One) <input type="checkbox"/> a. NEW enrollment <input type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage	<b>2. SOCIAL SECURITY NUMBER</b> _____	ACTION CODE (17) _____	LIST ALL PERSONS (including self) TO BE ENROLLED IN: (FIRST) (MI) (LAST)	DATE OF BIRTH Mo. Day Yr.			Family Relation- ship SELF	C O D E	
	<b>3. SPOUSE'S SOCIAL SECURITY NUMBER</b> _____		_____	_____	_____	_____	_____		
<b>4A. Name</b> (FIRST) (MI) (LAST)		SS# _____							
<b>Mailing Address</b> City, State, ZIP		SS# _____							
<b>4B. RESIDENCE ZIP CODE</b> (If different from 4A)		SS# _____							
5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only)	<b>6. SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>7. MARRIED</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	SS# _____						
<b>8. PLAN CODE</b>	<b>9. HEALTH PLAN:</b> <b>DENTAL PLAN:</b>		SS# _____						
<b>10. GROSS PREMIUM</b> \$	<b>11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP</b>		SS# _____						
<b>12. PRIOR PLAN CODE</b>	<b>13. PRIOR HEALTH PLAN</b>		SS# _____						
<b>14. Permitting Event Code</b>	<b>15. Permitting Event Date</b> Mo. Day Year	<b>16. EFFECTIVE DATE</b> Mo. Day Year	<b>18. SUPPLEMENTAL PLAN</b> (FIRST) (MI) (LAST)	DATE OF BIRTH Mo. Day Yr.			Relation- ship	C O D E	
_____	_____	_____ 01	_____	_____	_____	_____			

**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 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)

**Campus Phone:** \_\_\_\_\_

**21. DATE SIGNED**  
 Mo. Day Year

▶ **PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27** ◀

<b>22. DEDUCTION PLAN CODE</b>	<b>23. Type of action</b> (Check One) 1. <input type="checkbox"/> NEW 2. <input type="checkbox"/> CANCEL 3. <input type="checkbox"/> CHANGE	<b>24. PAY PERIOD</b> Month Year	<b>25. PARTY CODE</b>	<b>26. EMPLOYEE DESIGNATION</b>	<b>27. BARGAINING UNIT</b>
<b>28. AGENCY NAME (or Retirement System)</b> Humboldt State University			<b>29. PAYROLL OFFICE CODE</b> 0	<b>30. AGENCY CODE</b>	<b>31. UNIT CODE</b>
<b>32. I hereby certify under penalty of perjury as follows:</b> That I am a duly appointed, qualified and acting officer of the above named agency, and that the 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 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.			<b>SIGNATURE OF HEALTH BENEFITS OFFICER</b>	<b>33. Date received in employing office.</b> Mo. Day Yr.	<b>34. PHONE NUMBER</b> (707) 826-3626

**35. REMARKS**



California Public Employees' Retirement System  
 Health Benefit Services Division  
 P.O. Box 942714; Sacramento, CA 94229-2714  
 (800) 237-3345

**Declaration of Health Coverage**  
**HB-12A (01/01/98)**

**(INSTRUCTIONS ON REVERSE)**

<p>1. <b>EMPLOYEE INFORMATION</b> SOCIAL SECURITY NUMBER</p>	<p>2. <b>NAME</b> (FIRST) (MIDDLE) (LAST)</p>
<p>3. <b>PART A</b> <input type="checkbox"/> I elect to enroll myself and all eligible dependents.</p>	
<p><b>PART B-1</b> <input type="checkbox"/> I elect to enroll myself. My eligible dependents have other health insurance coverage.</p>	<p>If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment with 60 days from the date you lose coverage.</p>
<p><b>PART B-2</b> <input type="checkbox"/> I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage.</p>	<p><b>If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.</b></p>
<p><b>PART C-1</b> <input type="checkbox"/> I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.</p>	<p><b>If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.</b></p>
<p><b>PART C-2</b> 2. <input type="checkbox"/> I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.</p>	<p>You can request enrollment for yourself and/or your dependents at any time. <b>You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.</b></p>

**PART B:** If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependent, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

**PART C:** If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependent, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

**Special rules apply to retirement and death. Please read the back of this form carefully.**

4. \_\_\_\_\_  
 Member's Signature  
 HB-12A (01/98)

5. \_\_\_\_\_  
 Date Signed  
 Original: Employee's Personnel File

\_\_\_\_\_  
 Health Benefits Officer's Signature  
 Copy: Employee

## INSTRUCTIONS - DECLARATION OF HEALTH COVERAGE (HB-12A)

<i>Please contact your Health Benefits Office if you have any questions regarding the HB-12A</i>	
<b>Employee Information</b>	Complete with the appropriate employee information.
<b>PART A:</b>	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
<b>PART B-1:</b>	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage.
<b>PART B-2:</b>	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
<b>PART C-1:</b>	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
<b>PART C-2:</b>	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

**IMPORTANT:** It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

### Special rules for retirement and death:

Consider these points as you decided whether to enroll, decline, or cancel enrollment for yourself or dependents.

- If you are not enrolled in a CalPERS-sponsored health plan on the date you separate employment, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are not enrolled on your CalPERS-sponsored health plan at that time, they will not be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.