Fill in ONLY circled areas

Clear Print

PERS

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

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.

PERS 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'S SOCIAL SECURITY NUMBER — —

(4A.) Name (FIRST) (MI) (LAST)

Mailing Address

City, State, ZIP

(4B.) RESIDENCE ZIP CODE (If different from 4A)

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

(6.) SEX ☐ Male ☐ Female

(7.) MARRIED ☐ Yes ☐ No

8. PLAN CODE

(9.) HEALTH PLAN:
DENTAL PLAN:

10. GROSS PREMIUM $

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

14. Permitting Event Code

15. Permitting Event Date Mo. Day Year

16. EFFECTIVE DATE Mo. Day Year 01

ACTION CODE	(17.) LIST ALL PERSONS (including self) TO BE ENROLLED IN: (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	CODE
	[redacted]				SELF	
	SS#					
	SS#					
	SS#					
	SS#					
	SS#					
	SS#					
	SS#					
	SS#					
	SS#					

ACTION CODE	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Relationship	CODE

(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 elegible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in Itens 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 ◀

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)

Humboldt State University

29. PAYROLL OFFICE CODE

0

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 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.

SIGNATURE OF HEALTH BENEFITS OFFICER ▶

33. Date received in employing office. Mo. Day Yr.

34. PHONE NUMBER (707) 826-3626

35. REMARKS