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

n

HEALTH BENEFITS PLAN ENROLLMENT FORM
PERS-HBD 12 (Rev 8/02)

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'S SOCIAL SECURITY NUMBER
— —

ACTION CODE

LIST ALL PERSONS (including self) TO BE ENROLLED IN:

17. BASIC PLAN
(First) (MI) (LAST)

DATE OF BIRTH: MO. DAY Yr.

Family Relationship CODE

SELF

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. NAME OF HEALTH PLAN

10. GROSS PREMIUM
$

11. PRIMARY CARE PHYSICIAN /MEDICAL GROUP

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

18. SUPPLEMENTAL PLAN
(First) (MI) (LAST)

DATE OF BIRTH: Mo. Day Yr.

Family Relationship CODE

14. Permitting Event Code

15. Permitting Event Date
Mo. Day Yr.

16. EFFECTIVE DATE
Mo. Day Yr.

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 select 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 22825-22832 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made the Board of Administration, California 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 – HBD PINK – Agency BLUE - Employee

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the 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, CalPERS, PO Box 942702, Sacramento, CA 94229-2702.

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 request 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 California 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.

HBD-12

Introduction

Members with active employment status must complete and submit an HBD-12 form to their employer before enrolling for health benefits. Employers keep the completed HBD-12 in a file and should give the member a copy.

HBD-12 Instructions

The table below details the steps you must take to complete an HBD-12 form.

	Active Members	Employers
Members and Employers	Please complete the following boxes 1, 2, 3, 4A, 4B, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 19, 20 and 21. Contact your employer's Health Benefits Officer (HBO) or Personnel Office if you require further assistance.	Please complete the following boxes 14, 15, 16, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34 and 35. If an employee requires assistance completing this form, please provide support where possible.
	MEMBER'S BOXES are **white**.	*EMPLOYER'S BOXES* are **shaded gray**.
Retired Members	To make an Open Enrollment change, complete the request form **HBD-30**, and mail it to CalPERS. If you prefer, you may call CalPERS to make changes over the phone. All changes are subject to verification of eligibility.	

Mail HBD-30 requests to:	**Or contact:**
Office of Employer & Member Health Services P.O. Box 942714 Sacramento, CA 94229-2714	**CalPERS** (with questions on the HBD-12…if applicable) Toll Free: **888 CalPERS** (or **888**-225-7377) **TTY**: 800-735-2929 **FAX**: 916-795-1277

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<table>
<tr><th>Box</th><th>Process</th></tr>
<tr><td><u>1</u>
Type of Action
(required)</td><td>Check one:
<table>
<tr><td>New</td><td>Not enrolled</td></tr>
<tr><td>Change</td><td>Is enrolled and either:
• Changing health plans (when authorized)
• Adding family members
• Deleting family members
• Changing to a Medicare Coordinated plan (at retirement)</td></tr>
<tr><td>Cancel</td><td>Canceling all coverage</td></tr>
</table></td></tr>
<tr><td><u>2</u> and <u>3</u>
Social Security Number
(required)</td><td>Enter your Social Security Number (SSN) and spouse or domestic partner’s SSN. You may process this form without a SSN; however, you must provide each one as soon as possible.</td></tr>
<tr><td><u>4A</u>
Name and
Mailing Address</td><td>Enter your name as shown on the appointment document. Do not use nicknames. Enter your RESIDENCE or mailing address.</td></tr>
<tr><td><u>4B</u>
Residence ZIP Code</td><td>Enter a ZIP Code to find an eligibility ZIP Code. If a mailing address is different from the residential address, include the Residence ZIP Code in Box 4B. If you decide to use a work ZIP Code, include that ZIP Code in Box 4A.</td></tr>
<tr><td><u>5</u>
Permanent Intermittent
(State/CSU Only)</td><td>Check this box if you are a Permanent Intermittent (PI) employee.</td></tr>
<tr><td><u>6</u> and <u>7</u>
Sex and Marital Status</td><td>Check the appropriate box:

Yes- if married, separated
No- if unmarried or received a final divorce decree</td></tr>
<tr><td><u>8</u> and <u>9</u>
Plan Code and
Health Plan</td><td>Refer to the “Health Program Guide” or CalPERS On-Line at <u>www.calpers.ca.gov</u>, by searching in the Health Program Publications section. Enter the correct plan code and the name of the health plan.</td></tr>
</table>

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HBD-12 Instructions (continued)

Box	Process
10 ***Gross Premium***	Using the applicable rate sheet, enter the full gross premium as shown in *dollars* and *cents*. For assistance, access **CalPERS On-Line**, at **www.calpers.ca.gov** , and search for the *Health Plan Rates*.
11 ***Primary Care Physician***	Enter the name of a primary care physician and/or medical group. If you select an HMO but do not designate a Primary Care Physician/Medical Group, the plan will select one for you.
12 and **13** ***Prior Plan Code, Prior Health Plan***	Enter this information only if you are changing plans or canceling coverage. For assistance, access **CalPERS On-Line** at **www.calpers.ca.gov** , and search for the *Health Plan Rates*.
14 ***Permitting Event Code (Reason Code)***	Enter the appropriate transaction code, by locating the appropriate code in the Events/Reason Codes section of your manual. Complete a separate HBD-12 for each transaction that involves a different reason code or effective date.
15 ***Permitting Event Date*** (required)	Enter the date of an event that permits a change. Examples**:** The employee's appointment date, the date of marriage or divorce, the date of death, or the birth date of a dependent.
16 ***Effective Date*** ***Permissive*** *and* ***Mandatory Transactions***	**Permissive transactions** are effective on the first of the month following the date the agency receives an enrollment form (Box 33), within 60 days of event. **Mandatory transactions** are effective on the first of the month following an event (Box 15). For Open Enrollment transactions, refer to the Open Enrollment section of your manual. For additional information on effective dates, refer to the Events, Effective Dates, and Reason Codes sections of your manual.

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Members and Employers (continued)

<table>
<tr><th>Box</th><th>Process</th></tr>
<tr><td><u>17</u> and/or <u>18</u>
Enrolled Family Members</td><td>Use the appropriate Action Code to indicate additions or deletions of family members.

<table>
<tr><th>Action Code</th><th>Procedure</th></tr>
<tr><td>A</td><td>Use A to indicate the addition of family member(s), such as a new enrollment; mark the Action Code to the left of each enrollee’s name</td></tr>
<tr><td>D</td><td>Use D to indicate the deletion of family member(s)</td></tr>
</table>

<u>Note</u>: Do not use Action Codes to change plans or to cancel coverage (use boxes 1 and 19 to change plans or cancel coverage). When adding or deleting dependents, place an Action Code next to their name(s), then list additional family members names (but do not add an Action Code).

List all family members as follows (avoid nicknames):
• First name (full)
• Middle (abbreviation)
• Last name (full)

List birthdate(s) as: MM/DD/YYYY

If possible, list Social Security Numbers for dependents other than a spouse (required) in Box 35 (Remarks).

Abbreviations for family relationship codes:
<table>
<tr><th>Family Relationship</th><th>Abbreviation</th></tr>
<tr><td>Wife</td><td>Wife</td></tr>
<tr><td>Husband</td><td>Husb</td></tr>
<tr><td>Son</td><td>Son</td></tr>
<tr><td>Daughter</td><td>Dtr</td></tr>
<tr><td>Stepson</td><td>S/Son</td></tr>
<tr><td>Stepdaughter</td><td>S/Dtr</td></tr>
<tr><td>Adopted Son</td><td>A/Son</td></tr>
<tr><td>Adopted Daughter</td><td>A/Dtr</td></tr>
<tr><td>All Others</td><td>Specify</td></tr>
</table>

<u>Note</u>: A Family Code is not required.</td></tr>
</table>

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Members and Employers (continued)

<table>
<tr><th>Box</th><th>Process</th></tr>
<tr><td><u>19</u>
Check One</td><td>
<table>
<tr><td>I do not wish to enroll</td><td>Check this box only when you wish to decline Health Benefits coverage. Request a copy from your HBO or Personnel Office.</td></tr>
<tr><td>I elect to enroll</td><td>Check this box for new enrollments and enrollment changes.</td></tr>
<tr><td>I elect to cancel</td><td>Check this box only for cancellation of all coverage, including “self.” Do not check this box when deleting a family member.</td></tr>
</table>
</td></tr>
<tr><td><u>20</u>
Employee or
Annuitant Signature</td><td>You <u>must sign</u> the <u>HBD-12</u>.

By doing so you:
• Authorize premium deductions
• Verify a health plan selection
• Verify the eligibility of all enrolled family members
• Please include a daytime phone number</td></tr>
<tr><td><u>21</u>
Date Signed</td><td>Enter the month, day, and year.

<u>Remember</u>: Permissive enrollment transactions are valid only when they are received in the employer’s office and dated within 60 calendar days from the event date.

This is the last BOX a member/employee completes; the rest of the form must be processed by an HBO.</td></tr>
<tr><td><u>22-27</u>
(Active State Employees only…all others, skip to Box 28)</td><td><u>Note</u>: The State Controller’s Office requires this information to start, change, or stop premium payments.
Do not complete Boxes 22-27 if the transaction does not affect the premium payment, such as when adding a fourth family member.</td></tr>
<tr><td><u>22</u>
Deduction Code</td><td>Refer to Box 8 for instructions. Enter the 3-digit plan code, excluding the party code (last digit).

<u>Examples</u>: Kaiser code 563 Coverage, enter: 056 (3 digit codes are preceded by 0). CCPOA Code 2742 Coverage, enter: 274.</td></tr>
<tr><td><u>23</u>
Type of Action</td><td>Check the appropriate box (same as Box 1)

<u>Note</u>: The cancel and change boxes are listed in reverse order for key−entry reasons.</td></tr>
</table>

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<table>
<tr><td><u>24</u>
Pay Period</td><td>A pay period is the month prior to an effective date. In the three boxes, enter two digits for the pay period month and a last digit for the appropriate year.

<u>Examples</u>:

<table><tr><th>Effective Date</th><th>Pay Period (Digits)</th></tr><tr><td>11/01/05</td><td>10 5</td></tr><tr><td>3/01/06</td><td>02 6</td></tr></table></td></tr>
<tr><td><u>25</u>
Party Code</td><td>Enter the last digit of the plan code (1, 2, or 3).</td></tr>
<tr><td><u>26</u>
Employee Designation</td><td>Enter the appropriate alpha code:

<table><tr><th>Alpha Code</th><th>Designation</th></tr><tr><td>R</td><td>Rank and file employees</td></tr><tr><td>S</td><td>Supervisory employees</td></tr><tr><td>M</td><td>Management</td></tr><tr><td>C</td><td>Confidential employees</td></tr><tr><td>E</td><td>Excluded</td></tr></table></td></tr>
<tr><td><u>27</u>
Bargaining Unit</td><td>Enter the appropriate two-digit collective bargaining unit code.</td></tr>
<tr><td><u>28</u>
Agency Name</td><td>Enter the agency’s name (do not abbreviate).</td></tr>
<tr><td><u>29</u>
Payroll Office Code</td><td>Enter the appropriate code, referring to the Payroll Office Code section for a complete listing.</td></tr>
<tr><td><u>30</u> and <u>31</u>
Agency and Unit Code</td><td>Enter an employer’s three-digit agency and unit code (where applicable).</td></tr>
<tr><td><u>32</u>
Signature of Health Benefits Officer (required)</td><td>Signature of authorized Health Benefits Officer or assistant (signature must be legible).</td></tr>
<tr><td><u>33</u>
Date Received in Employing Office</td><td>The employing office where an employee receives his or her lowest level of supervision (local timekeeper or attendance clerk).</td></tr>
<tr><td><u>34</u>
Phone Number</td><td>Enter the public phone number of the Health Benefits Officer or assistant who is the contact for an enrollment document.</td></tr>
</table>

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35 ***Remarks***	Use this section to enter additional information pertinent to the enrollment action and in numbering multiple documents. When there are multiple documents, please number them 1/4, 2/4, etc. You can also use this Box to: • List completed hours for a PI employee • Certify an HBD-35 is on file for an economic dependent addition • Explain coordination of coverage between family members • Verify a family member's eligibility • Explain any special circumstances

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