



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

**HEALTH BENEFIT PLAN**

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

**CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER**

**PLEASE TYPE**

1. TYPE OF ACTION (Check One)  <input type="checkbox"/> a. NEW enrollment <input type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage	2. SOCIAL SECURITY NUMBER  _____		A C C T I O N	LIST ALL PERSONS (including self) TO BE ENROLLED IN:			DATE OF BIRTH			Family Relationship	G E N D E R  M F	C O D E
	3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER  _____			17. BASIC PLAN			Mo.	Day	Yr.			
4A. Name			SSN									
Mailing Address (FIRST) (MI) (LAST)			(FIRST) (MI) (LAST)									
City, State, ZIP Daytime Phone Evening Phone			SSN									
4B. RESIDENCE ZIP CODE (If different from 4A)			(FIRST) (MI) (LAST)									
5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only)		6. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		7. MARRIED <input type="checkbox"/> Yes <input type="checkbox"/> No		SSN						
						(FIRST) (MI) (LAST)						
8. PLAN CODE		9. NAME OF HEALTH PLAN		SSN								
10. GROSS PREMIUM \$		11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP										
12. PRIOR PLAN CODE		13. PRIOR HEALTH PLAN		A C C T I O N	18. SUPPLEMENTAL PLAN			DATE OF BIRTH			Relation-ship	C O D E
					(FIRST) (MI) (LAST)			Mo.	Day	Yr.		
14. Reason Code		15. Permitting Event Date Mo. Day Yr.		16. EFFECTIVE DATE Mo. Day Yr.								

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 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. <input type="checkbox"/> New 2. <input type="checkbox"/> Cancel 3. <input type="checkbox"/> 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 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	33. Date received in employing office Mo. Day Year	34. PHONE NUMBER  ( )
	35. REMARKS  _____ of _____ Forms		

WHITE - HB PINK - Agency BLUE - Employee