SAN JOSÉ STATE UNIVERSITY

RESEARCH FOUNDATION

SJSU RESEARCH FOUNDATION ENROLLMENT FORM

The following information is needed to complete documentation into a CALPERS health insurance plan.

Name_____Soc. Sec.#_____

Mailing Address_____

_____

Phone (Home)_____(Work)_____Email_____

Male_____Female_____Single_____Married_____

Medical Plan Choice	Employee*	Spouse*	Children*
_____Blue Shield HMO*	_____	_____	_____
_____Blue Shield NetValue*	_____	_____	_____
_____Kaiser			
_____PERS-Care			
_____PERS Choice			
_____PERS-Select			

***HMO only**: Please enter name of Physician and or Medical Group selection under each person.

List all persons (including yourself) to be enrolled in your health insurance plan.

	Name	Date of Birth	SS#	Relationship
1.				
2.				
3.				
4.				

(Please use the backside if more space is needed)

Are you or other family members currently enrolled in another PERS plan? ____

I elect to enroll in (or change to) the plan shown above and authorize a deduction (if any applies) to be made from my salary to cover my share of the cost as it is now or as it may be in the future.

_____ _____

Signature Date

For Official Use Only: Plan Code_____Plan Name_____Gross Premium_____

Permitting Event Code_____Permitting Event Date_____Effect. Date_____

June 2011

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

HEALTH BENEFIT PLAN ENROLLMENT FORM

PERS-HBD-12 (Rev.8/10)

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/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER ___ ___

4A. Name

Mailing Address (FIRST) (MI) (LAST)

City, State, ZIP | Daytime Phone | Evening Phone

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

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

6. GENDER ☐ 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

14. Reason Code

15. Permitting Event Date Mo. Day Yr.

16. EFFECTIVE DATE Mo. Day 01 Yr.

ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	GENDER M	F	CODE
	17. BASIC PLAN							
	(FIRST) (MI) (LAST)				SELF			
	SSN							
	(FIRST) (MI) (LAST)							
	SSN							
	(FIRST) (MI) (LAST)							
	SSN							
	18. SUPPLEMENTAL PLAN	DATE OF BIRTH Mo.	Day	Yr.	Relationship			CODE
	(FIRST) (MI) (LAST)							

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. ☐ 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 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

CalPERS

Office of Employer and Member Health Services
PO Box 942714
Sacramento, CA 94229-2714
Toll Free: (888) CalPERS (225-7377) Fax: (916) 795-1313
Telecommunications Device for the Deaf: (916) 795-3240

Declaration of Health Coverage: HBD-12A **(INSTRUCTIONS ON REVERSE)**

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME (FIRST) (MIDDLE) (LAST)

PART A ☐ I elect to enroll myself and all eligible dependents.	
PART B-1 ☐ I elect to enroll myself. My eligible dependents have other health insurance coverage.	If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage. **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.**
PART B-2 ☐ I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage.	
PART C-1 ☐ I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.	
PART C-2 ☐ I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.	You can request enrollment for yourself and/or your dependents at any time. **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.**

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 dependents, 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 dependents, 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.

Member's Signature

Date Signed

Health Benefits Officer's Signature

Rev (3/09)

Original: Employee's Personnel File

Copy: Employee

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

Please contact your Health Benefits Officer if you have any questions regarding the HB-12A	
Employee Information	Complete with the appropriate employee information.
PART A:	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.
PART B-1:	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.
PART B-2:	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.
PART C-1:	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.
PART C-2:	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 eligible to be enrolled in a CalPERS-sponsored health plan on the date you separate employement, 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 enrolled on your CalPERS-sponsored health plan at this time, they may be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.