## Sample HBD-12 New Enrollment Using Workplace ZIP Code Election Form on file.

HEALTH BENEFIT PLAN ENROLLMENT FORM	NROLLMENT FORM DO NOT SEND MEDICAL											
PERS-HBD-12 (Rev. 10/93) CLAIMS TO THIS ADDRESS PERS USE ONLY-DOCUME PLEASE TYPE									NUME	ER		
1. TYPE OF ACTION	2. SOCIAL SECURIT	-		D	ATE (	)F	Family	c				
(Check One)		Ty NUMBER 6789			BE ENROLLED IN:	• (		BIRTH		Relation-	O D	
a. NEW enrollment	3. SPOUSE'S SOCIAL		IIMBER	Ň	the second s	(MI)	(LAST)	Mo.	Day	Yr.	ship SELF	<u> </u>
b. CHANGE of coverage	C. CANCEL all coverage					Т.	Pooh	08	28	55	occi	
4A. Winnie T. Pooh												
Mailing 4563 Disney Avenue (Home Addr.)												
0.1	ille, CA 95501											·
4B. RESIDENCE ZIP CC	IDE (If different from 4A	)			· · · · · · · · · · · · · · · · · · ·							
5. Please check if Permanent Intermittent	6. SEX Male	7. MARRIED										
Employee (applies to active State employees only)	Yes No											
8. PLAN CODE	9. NAME OF HEALT	H PLAN						$\left[ - \right]$	-+			
2381	PacifiCare of C 11. PRIMARY CARE PHY											
10. GROSS PREMIUM \$ 205.48												
\$ 205.48 Dr. Johnny Richleand 12. PRIOR PLAN CODE 13. PRIOR HEALTH PLAN												
12. FRIOR FLAN GODE	15. FRIOR HEALTH				18. SUPPLEMENT	PPLEMENTAL PLAN			OF B	IRTH	Relation-	с 0 р
14. Permitting Event Code 15. Permitting Event Da		16. EFFECTIV			(FIRST)	(MJ)	(LAST)		Day		ship	D E
	Mo. Day Year	Mo. Day	Year									
1 5 1	10 01 <sup>01</sup>	11   01	01			<u> </u>						
<ul> <li>19. CHECK ONE</li> <li>I DO NOT wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.</li> <li>✓ 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.</li> <li>□ I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.</li> </ul>												
20. EMPLOYEE OR ANN	JITANT'S SIGNATURE	(see privacy	informa	ition	on reverse)		Jan, 11	1 14	-	0	GNED	
► /S/Winnie T. Po	oh	Da	ytime	e Phone (916) 555-5555 10 10 102 101								ir
	D THE HEALTH BI											◀
22. DEDUCTION PLAN CODE   2   3   8 (Check One	2. Cancel	24. PAY PER Month 10   01	Year 01	25.	PARTY CODE	26. Empl Desic R	INATION	27.	BAR	GAIN 04	ing uni 4	T
28. AGENCY NAME (or Retire				29.	PAYROLL OFFICE CODE			31.	UNIT	CODE		
Department of F		ninistratio	on		0	33				18	0	
32. I hereby certify under pena	aity of perjury as follows:	SIGNATURE O	F HEALT	H BE	NEFITS OFFICER	33. Date rec		34.	PHON	E NU	MBER	
That I am a duly appointed, a of the above named agency,	and that payment by the	▶/S/ Mir	nnie	Fo	olke	emplovin Mo. Day 09   28		(9 <sup>.</sup>	16)	333	3-282	8

	Public Employees' Retirement System Post Office Box 942714 Sacramento, CA 94229-2714												
HEALTH BENEFIT PLAN ENROLLMENT FORM	DO NOT SEND MEDICAL			PERS use only-document reference number									
PERS-HBD-12 (Rev. 10/93)		EASE	тν		DNLY-	DOCUMENT REFERE	INCE	NUM	BER				
1. TYPE OF ACTION (Check One)	2. SOCIAL SECURITY NUMBER		Ŷ.	E LIST ALL PERS	IN:	ncluding self) TO		DATE BIRT		Family Relation-	с 0 р		
a. NEW enrollment	519 - 90 - 9000		o i	TT. BASIC PLA	(MI)	(LAST)	Mo	. Day	Yr.	ship	E		
b. CHANGE of coverage	3. SPOUSE'S SOCIAL SECURITY N 527 - 36 - 4871	NUMBER		Mary	J.	Carling	04	10	50	SELF			
4A. Mary	J. Carling			Frank	М.	Carling	05	04	60	husb.			
Mailing (FIRST) Address	ping Jack Lane (New A	ddr)	_	Patricia	J.	Carling	04	04	90	dtr.			
City, State, ZIP LOS AN 4B. RESIDENCE ZIP CO	geles, CA 92001 DDE (If different from 4A)												
5. Please check if	6. SEX 7. MARRIED												
Permanent Intermittent	Male Yes												
Employee (applies to active State employees only)	Female No		-								·		
8. PLAN CODE 2323	9. NAME OF HEALTH PLAN Universal Care		┣										
10. GROSS PREMIUM	11. PRIMARY CARE PHYSICIAN/MEDICAL	GROUP							-				
\$ 438.39	Dr. Nathan Goodledge								-+				
12. PRIOR PLAN CODE	13. PRIOR HEALTH PLAN												
563	Kaiser			18. SUPPLEMEN (FIRST)	(MI)			OF B	Yr.	Relation-	000		
14. Permitting Event Code	15. Permitting Event Date 16. EFFECTIV Mo. Day Year Mo. Day	E DATE Year						7			<u>_</u>		
4 0 2	09 27 <sup>01</sup> 10 01	01											
19 CHECK ONE										· · · · ·			
I elect to ENROLL IN salary or retirement a all dependents listed of	enroll in a Health Benefits Plan under the (OR CHANGE TO) a Health Benefits Pla Illowance to cover my share of the cost a above in Items 17 and/or 18 are eligible the Health Benefits Plan as shown in Ite	an as sha of enrolln family m	own i nent c nemb	in Items 8 and 9 at as it is now or as it ars as defined in the	nay b	nd authorize deduc a in the future. I als	ction: so ce	rtify t	hat th	e names c	of		
	JITANT'S SIGNATURE (see privacy						21. M		E SI Day	GNED Yea			
▶ /S/ Mary J. Carl				ne Phone (6			09		27	01			
	D THE HEALTH BENEFITS PR										<b>▲</b>		
22. DEDUCTION PLAN CODE 2 3 2 Check 0ne	2. Cancel Month	Year 01	25.	PARTY CODE	20.	Employee Designation R	27. BARGAINING U 07				1		
				PAYROLL OFFICE COD	E 30.	AGENCY CODE	31.	UNIT	CODE				
Department of F	Rehabilitation			0		534			60	0			
32. I hereby certify under pena	ity of perjury as follows: SIGNATURE OF	F HEALT	H BE	NEFITS OFFICER		Date received in employing office	34. PHONE NUMBER						
	and that payment by the			Marks	мо. 09	Day Yr. 28 01	(916) 323-0000				0		
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 determino- tion 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.													

## Sample HBD-12 Changing Plans during Open Enrollment Using Workplace ZIP Code Election Form on file.

	Sacramento, CA 94229-2714													
HEALTH BENEFIT PLAN ENROLLMENT FORM	DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS				PERS USE ONLY-DOCUMENT REFERENCE NUMBER									
PERS-HBD-12 (Rev. 10/93) CLAIMS TO THIS ADDRESS PERS USE ONLY-DOCUMENT REFERENCE NUMBER														
					E LIST ALL PERSONS (including self) TO BE ENROLLED IN:					OF 1	Family Relation-	C O D		
a. NEW enroliment						PLAN		Mo.	Day	Yr.	ship	E		
b. CHANGE of coverage	3. SPOUSE'S SOCIAL 321 — 65 —	_ Security N - 4563	UMBER		(FIRST) Dannie	(M) M.	(LAST) Boone	04	14	58	SELF			
4A. Dannie		one			Sarah	Α.	Boone	01	11	59				
Mailing Address 9641 Betty Boope Dr. (Home Addr)														
City, State, ZIP Las Veg	gas, NV 89021			-			4							
4B. RESIDENCE ZIP CO			Work											
5. Please check if 6. SEX Permanent Intermittent Employee (applies to active Male Yes														
State employees only)	Female	No												
8. PLAN CODE 2052	9. NAME OF HEALT Blue Shield Acc	H PLAN ccess+ HN	10											
10. GROSS PREMIUM	11. PRIMARY CARE PHY	SICIAN/MEDICAL	GROUP							T				
\$ 433.32	Margie Succe	$\vdash$		·····										
12. PRIOR PLAN CODE	13. PRIOR HEALTH PLAN													
2222	PERS Choice			ÊS	18. SUPPLEN	MENTAL	PLAN (LAST)	DATE Mo.		IRTH Yr.	Relation- ship	0		
14. Permitting Event Code	15. Permitting Event Date Mo. Day Year	16. EFFECTIV Mo. Day	E DATE Year	10 61				mu,			Sinp	<u>E</u>		
4 1 2	09 03 01	01   01	02											
19 CHECK ONF			1	<b>I</b> !				1			L			
i elect to ENROLL IN salary or retirement al all dependents listed a	nroll in a Health Benefi (OR CHANGE TO) a He llowance to cover my sha ubove in Items 17 and/or ne Health Benefits Plan	alth Benefits Pla are of the cost a 18 are eligible	an as sh of enrolln famity n	own i nent c nemb	n Items 8 and 9 as it is now or a ers as defined in	9 above o is it may b	and authorize dedu be in the future. I al	ctions so ce	rtify tl	hat th	e names a	of		
20. EMPLOYEE OR ANNL	IITANT'S SIGNATURE	(see privacy	informa						21. DATE SIGNED					
/S/Dannie M. Bo	one	Day	time F	Phone (916) 555-5555					Mo. Day Year 09 05 01					
PLEASE REFER TO	THE HEALTH BE	ENEFITS PR	OCED	URE	MANUAL	FOR C	OMPLETION	OF	ITEA	AS 2	22-27	◄		
22. DEDUCTION PLAN CODE 23. Type of action	1. New 2. Cancel	24. PAY PER Month	IOD Year	25.	PARTY CODE	E 26	. EMPLOYEE Designation	27.	BAR		ING UNI	T		
2 0 5 (Check One	) 3. Change	1 2	2		2		E			99	9			
28. AGENCY NAME (or Retires	nent System)			29.	PAYROLL OFFICE	CODE 30.	AGENCY CODE	31.	UNIT	CODE				
Department of Motor Vehicles					0		525	310						
32. I hereby certify under pena	ity of perjury as follows:	SIGNATURE O	F HEALT	H BE	NEFITS OFFICEF		employing office	34.	PHONE	e nui	MBER			
That I am a duly appointed, a of the above named agency, agency as provided by Section	and that payment by the				Jones	0.0	) 10   01	(9'	16) (	333	3-282	8		
Government Code is hereby of toon of eligibility for the enroli be made by the Board o Employees' Retirement System Public Employees' Medical on the regulations implementing th	ment action specified will f Administration, Public a, in accordance with the d Hospital Care Act and			-	Forms	ompiete	boxes 22-24				2			

Change of plan outside of Open Enrollment Using Residence/Work ZIP Code. Employer ZIP Code Election Form on file.

	Public Employees' Retire Post Office Box 942714 Sacramento, CA 9422														
HEALTH BENEFIT PLAN ENROLLMENT FORM DO NOT SEND MEDICAL PERS-HBD-12 (Rev. 10/93) CLAIMS TO THIS ADDRESS				PERS use only-document reference number											
PERS_HBD-12 (Kev. 10/93) CLAIMS TO THIS ADDRESS PERS USE UNLY_DOCUMENT REPERENCE NUMBER															
						D	ATE ( BIRTH		Family	c O					
(Check One)	654 — 32 — 0897				¢ c LIST ALL PERSONS (including self) TO ↑ B E ENROLLED IN: №					Yr.	Relation-	DE			
a. NEW enrollment b. CHANGE of coverage c. CANCEL all coverage	3. SPOUSE'S SOCIAL SECURITY NUMBER 897 — 65 — 4321				(first) Diane	(MI) R.	(LAST) Waverly	Mo. 05	06		SELF				
<sup>4A.</sup> Diane	R. Waverly				Dennis	Т.	Waverly	06	05	58	Husb.				
Name Mailing 6754 Cl Address	ross Road Lan	e	(LAST)												
City, State 7/P Hollister, CA 95023															
4B. RESIDENCE ZIP CO	DE (If different from 4/	<sup>•)</sup> 95020(	Work					ĺ							
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 HEALT					· · · · · · · · · · · · · · · · · · ·			┝─┤						
562 10. GROSS PREMIUM	Kaiser Perman 11. PRIMARY CARE PHY		CPOUP					ļ	$\vdash$						
\$ 420.34	11. TRIMINAT WARE THE	JUINIT/ MILDIUNL	00001												
2222				Â Ç C I B	18. SUPPLEMEN	TAL	PLAN	DATE	OF B	IRTH	Relation-	000			
		PERS Choice 15. Permitting Event Date 16. EFFECTIVE DATE			(FIRST)	(MI)	(LAST)	Mo.	Day	Yr.	ship				
14. Fernitung Event Code	Mo. Day Year	Mo. Day	Year												
4 1 3	12 15 01	01   01	02												
19. CHECK ONE		••		<u> </u>					<u>_</u>	·····					
<ul> <li>I DO NOT wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.</li> <li>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.</li> <li>I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.</li> </ul>															
20. EMPLOYEE OR ANNL ► /S/Diane R. Way		• •			on reverse) (916) 555-12	212		M	0.	Da		ar			
						_		12		16	101				
22. DEDUCTION 23. Type of	1. New	24. PAY PER			PARTY CODE		EMPLOYEE					T			
$\begin{array}{c ccccccccccccccccccccccccccccccccccc$					2 26. EMPLOYEE 27. BARGAINING UN DESIGNATION 2 R 01						-				
28. AGENCY NAME (or Retire	ment System)			29.	PAYROLL OFFICE CODI	E 30.	AGENCY CODE	31.	UNIT	CODE					
CalPERS					0		275			53	30				
32. I hereby certify under pena	ity of perjury as follows:	SIGNATURE C	OF HEALT	H BE	NEFITS OFFICER	33.	Date received in employing office	34.	PHON	e nu	MBER				
That I am a duly appointed, a of the above named agency, agency as provided by Section	and that payment by the				-	Mo 12	<b>Day</b> Yr.	(9	16)	38	9-123	84			
Government Code is hereby a tion of eligibility for the enroll be made by the Board o Employees' Retirement System	Iment action specified will   of Administration, Public	JJ. KLMAKNJ	Public A of		cies do not comp Forms	olete	boxes 22-24								

Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.