P.O. Box 942715 Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | Fax: (800) 959-6545
www.calpers.ca.gov

California Public Employees' Retirement System

{date}

{Recipient Name}
{Recipient Address}

CalPERS ID: {CalPERS ID}

Cancellation Notice

Dear {Participant Name}:

Your dependent(s) will be deleted from CalPERS health coverage effective {effective date} if you do not take action to verify your dependent(s) by {due date}.

To ensure only eligible dependents of State employees are enrolled in employer-sponsored health coverage, California Government Code section 22843.1 requires your employer to verify the eligibility of your dependent(s) at least once every three years. This letter outlines instructions for you to verify each dependent's eligibility with your employer. All requested information must be provided to your agency's personnel office by {Due Date} in order for your dependent(s) to continue receiving health coverage and avoid being cancelled on {effective date}.

If the verification is processed after the 10th of {birth month}, retroactive premiums may be owed resulting in an accounts receivable with the State Controller's Office.

If you have previously provided the required documentation to verify each dependent's eligibility outside of this effort, the documentation must be provided again for any dependents listed on the Dependent Verification Affidavit to comply with this new requirement.

Dependents that require verification

- Current spouse
- Current domestic partner as registered with the California Secretary of State's Office
- Natural-born, adopted (or placement for adoption), current step, or current registered domestic partner children up to age 26.

Instructions

Please complete these steps to verify your dependents' eligibility:

- Review the list of your dependent(s) below who requires verification.
- Make copies of any required verification documents listed below for each dependent.
- **Provide all required documents, including the completed Dependent Verification Affidavit included with this letter to your agency's personnel office by {Due Date}.**

The following dependent(s) require verification:

Enrolled Dependent Name	Relationship	Date of Birth
{Dependent Name}	{Relationship}	{DOB}
{Dependent Name}	{Relationship}	{DOB}
{Dependent Name}	{Relationship}	{DOB}

Note: If you currently have a disabled dependent(s) or a parent-child relationship dependent(s) enrolled in employer-sponsored health coverage, they are not included in this verification and their coverage continues as long as it is continuously certified. Dependents added to your health enrollment within the last six months do not need to be verified at this time. If you have a dependent who should be removed due to a qualifying event (i.e., divorce, family member enters military, etc.), please contact your agency's personnel office immediately.

Required Verification Documents

Review the table below to assist with the required and acceptable documentation needed to verify each dependent's eligibility. All required documents MUST include a date, your name, and the name of the dependent being verified.

Relationship Type	Acceptable Verification Documents
Spouse	A copy of your marriage certificate **AND** one of the following documents: • A copy of the front page of the most recent federal or state tax return confirming dependent as your spouse **OR** • A copy of a document dated within the last 60 days showing current relationship status, such as a recurring household bill or joint statement of account. The document must list your name, the name of your spouse, and your address.
Registered Domestic Partner	A copy of your Declaration of Domestic Partnership registered with the California Secretary of State **AND** one of the following documents: • A copy of the front page of the most recent federal or state tax return confirming dependent as your domestic partner **OR** • A copy of a document dated within the last 60 days showing current relationship status, such as a recurring household bill or joint statement of account. The document must list your name, the name of your partner, and your address.
Children (natural-born, adopted, placement for adoption, step, or registered domestic partner's children) up to age 26 (the month in which dependent attains age 26)*	• A copy of the child's birth certificate or adoption certificate naming you, your spouse, or your domestic partner as the parent of the child **OR** • A copy of the court order naming you, your spouse, or your domestic partner as the legal guardian of the child. * For a stepchild, or domestic partners child, you must also provide documentation of your current relationship to your spouse or domestic partner as requested above.

If you have any questions regarding this letter or any actions you are required to complete, please contact your agency's personnel office.

Please ensure the dependent(s) losing coverage receive this important information about continuation of coverage.

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers to extend group coverage to dependents that lose eligibility through the CalPERS Health Benefits Program.

Coverage may be continued for a maximum of 36 months from the termination date of dependent coverage. The premium is paid directly to the health plan at a rate not to exceed 102 percent of the group monthly premium rate. You may contact your health plan directly to obtain your specific premium amount. There is no employer contribution available toward the cost of COBRA continuation coverage. The coverage must be continuous, therefore, the effective date of the continuation will be the date of termination from the subscriber's coverage.

The election for continuation must be submitted within 60 days of receiving this notification or loss of coverage, whichever is later. Once the 60 day election period passes, the right to continue health coverage will end.

Additional details concerning the continuation of coverage under the provisions of COBRA may be obtained through the personnel office of the subscriber's employing agency.

Affordable Care Act Information:

The Affordable Care Act (ACA) allows individuals to access affordable coverage through the Health Insurance Marketplace. If you purchase your health coverage through one of these Health Insurance Marketplaces you may be eligible for government subsidies to help pay for health insurance premiums. The subsidies are based on your level of income and number of dependents in your family. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Health Insurance Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan). Contact the group health plan for additional information.

For additional details regarding the Health Insurance Marketplace in your state, visit www.healthcare.gov or call 1-800-318-2596. For additional information regarding the California Health Insurance Marketplace, visit Covered California at www.coveredca.com or call 1-800-300-1506.

For medical claim status, benefit information, identification card, booklets, or claim forms contact:

{carrier name}
{carrier contact address}
{carrier phone number}

We are here to assist you. You may log in to your my|CalPERS account at **my.calpers.ca.gov** to access your health benefits online or to send a secure message. You may find additional answers to your questions by visiting our website at **www.calpers.ca.gov**, or you may call us toll free at **888 CalPERS** (or **888**-225-7377).

Sincerely,

{Unit name}
{Division name}