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

PERS

Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN ENROLLMENT FORM

PERS—HBD-12 (Rev. 10/93)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

▶ PLEASE TYPE ◀

1. TYPE OF ACTION (Check One)
- [x] a. NEW enrollment
- [ ] b. CHANGE of coverage
- [ ] c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER: 123 — 45 — 6789

3. SPOUSE'S SOCIAL SECURITY NUMBER: — —

4A. Name: Winnie T. Pooh (FIRST) (MI) (LAST)

Mailing Address: 4563 Disney Avenue (Home Addr.)

City, State, ZIP: Marysville, CA 95501

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

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

6. SEX: [ ] Male [x] Female

7. MARRIED: [ ] Yes [x] No

8. PLAN CODE: 2381

9. NAME OF HEALTH PLAN: PacifiCare of California

10. GROSS PREMIUM: $ 205.48

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP: Dr. Johnny Richleand

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

14. Permitting Event Code: 1 5 1

15. Permitting Event Date: Mo. 10 Day 01 Year 01

16. EFFECTIVE DATE: Mo. 11 Day 01 Year 01

ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	CODE
	17. BASIC PLAN (FIRST) (MI) (LAST)					
A	Winnie T. Pooh	08	28	55	SELF	
	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)					

19. CHECK ONE

- [ ] I **DO NOT** wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- [x] 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)
▶ /S/Winnie T. Pooh Daytime Phone (916) 555-5555

21. DATE SIGNED: Mo. 10 Day 02 Year 01

▶ PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22–27 ◀

22. DEDUCTION PLAN CODE: 2 3 8

23. Type of action (Check One): 1. [x] New 2. [ ] Cancel 3. [ ] Change

24. PAY PERIOD Month 10 Year 01

25. PARTY CODE: 1

26. EMPLOYEE DESIGNATION: R

27. BARGAINING UNIT: 04

28. AGENCY NAME (or Retirement System): Department of Personnel Administration

29. PAYROLL OFFICE CODE: 0

30. AGENCY CODE: 332

31. UNIT CODE: 180

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 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
▶ /S/ Minnie Folke

33. Date received in employing office: Mo. 09 Day 28 Yr. 01

34. PHONE NUMBER: (916) 333-2828

35. REMARKS Public Agencies do not complete boxes 22-24
_____ of _____ Forms

Sample HBD-12
Changing Plans based on a Move

PERS

Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN ENROLLMENT FORM
PERS—HBD-12 (Rev. 10/93)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

▶ PLEASE TYPE ◀

1. TYPE OF ACTION (Check One)
- [ ] a. NEW enrollment
- [x] b. CHANGE of coverage
- [ ] c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER: 519 — 90 — 9000

3. SPOUSE'S SOCIAL SECURITY NUMBER: 527 — 36 — 4871

4A. Name: Mary J. Carling (FIRST) (MI) (LAST)

Mailing Address: 10 Jumping Jack Lane (New Addr)

City, State, ZIP: Los Angeles, CA 92001

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

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

6. SEX: [ ] Male [x] Female

7. MARRIED: [x] Yes [ ] No

8. PLAN CODE: 2323

9. NAME OF HEALTH PLAN: Universal Care

10. GROSS PREMIUM: $ 438.39

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP: Dr. Nathan Goodledge

12. PRIOR PLAN CODE: 563

13. PRIOR HEALTH PLAN: Kaiser

14. Permitting Event Code: 4 | 0 | 2

15. Permitting Event Date: Mo. 09 | Day 27 | Year 01

16. EFFECTIVE DATE: Mo. 10 | Day 01 | Year 01

ACTION	CODE	17. BASIC PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	CODE
		Mary J. Carling	04	10	50	SELF	
		Frank M. Carling	05	04	60	husb.	
		Patricia J. Carling	04	04	90	dtr.	

ACTION	CODE	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Relationship	CODE

19. CHECK ONE

- [ ] I **DO NOT** wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- [x] 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): ▶ /S/ Mary J. Carling — Daytime Phone (610) 222-3333

21. DATE SIGNED: Mo. 09 | Day 27 | Year 01

▶ PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22–27 ◀

22. DEDUCTION PLAN CODE: 2 | 3 | 2

23. Type of action (Check One): 1. [ ] New 2. [ ] Cancel 3. [x] Change

24. PAY PERIOD: Month 0 | 9 | Year 01

25. PARTY CODE: 3

26. EMPLOYEE DESIGNATION: R

27. BARGAINING UNIT: 07

28. AGENCY NAME (or Retirement System): Department of Rehabilitation

29. PAYROLL OFFICE CODE: 0

30. AGENCY CODE: 534

31. UNIT CODE: 600

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 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: ▶ /S/Walker H. Marks

33. Date received in employing office: Mo. 09 | Day 28 | Yr. 01

34. PHONE NUMBER: (916) 323-0000

35. REMARKS: Public Agencies do not complete boxes 22-24 _____ of _____ Forms. Changing plans due to move.

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

CALIFORNIA PERS

Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN ENROLLMENT FORM
PERS—HBD-12 (Rev. 10/93)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

▶ PLEASE TYPE ◀

1. TYPE OF ACTION (Check One)
- [ ] a. NEW enrollment
- [x] b. CHANGE of coverage
- [ ] c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER: 546 — 12 — 9891

3. SPOUSE'S SOCIAL SECURITY NUMBER: 321 — 65 — 4563

4A. Name: Dannie (FIRST) M. (MI) Boone (LAST)
Mailing Address: 9641 Betty Boope Dr. (Home Addr)
City, State, ZIP: Las Vegas, NV 89021

4B. RESIDENCE ZIP CODE (If different from 4A): 90021 (Work)

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

6. SEX: [x] Male [ ] Female

7. MARRIED: [x] Yes [ ] No

8. PLAN CODE: 2052

9. NAME OF HEALTH PLAN: Blue Shield Acccess+ HMO

10. GROSS PREMIUM: $ 433.32

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP: Margie Success, M.D

12. PRIOR PLAN CODE: 2222

13. PRIOR HEALTH PLAN: PERS Choice

14. Permitting Event Code: 4 | 1 | 2

15. Permitting Event Date: Mo. 09 | Day 03 | Year 01

16. EFFECTIVE DATE: Mo. 01 | Day 01 | Year 02

ACTION	CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	CODE
		17. BASIC PLAN (FIRST) (MI) (LAST)					
		Dannie M. Boone	04	14	58	SELF	
		Sarah A. Boone	01	11	59		

ACTION	CODE	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Relationship	CODE

19. CHECK ONE

- [ ] I **DO NOT** wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- [x] 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): ▶ /S/Dannie M. Boone — Daytime Phone (916) 555-5555

21. DATE SIGNED: Mo. 09 | Day 05 | Year 01

▶ PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22–27 ◀

22. DEDUCTION PLAN CODE	23. Type of action (Check One)	24. PAY PERIOD Month	Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
2 | 0 | 5	1. [x] New 2. [ ] Cancel 3. [ ] Change	1 | 2	2	2	E	99

28. AGENCY NAME (or Retirement System)	29. PAYROLL OFFICE CODE	30. AGENCY CODE	31. UNIT CODE
Department of Motor Vehicles	0	525	310

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualifed 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 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: ▶ /S/ Personnel Jones

33. Date received in employing office: Mo. 09 | Day 10 | Yr. 01

34. PHONE NUMBER: (916) 333-2828

35. REMARKS Public Agencies do not complete boxes 22-24
_____ of _____ Forms

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

CALIFORNIA PERS

Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN ENROLLMENT FORM
PERS—HBD-12 (Rev. 10/93)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

PERS 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: 654 — 32 — 0897

3. SPOUSE'S SOCIAL SECURITY NUMBER: 897 — 65 — 4321

4A. Name: Diane R. Waverly (FIRST) (MI) (LAST)

Mailing Address: 6754 Cross Road Lane

City, State, ZIP: Hollister, CA 95023

4B. RESIDENCE ZIP CODE (If different from 4A): 95020(Work

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

6. SEX: ☐ Male ☑ Female

7. MARRIED: ☑ Yes ☐ No

8. PLAN CODE: 562

9. NAME OF HEALTH PLAN: Kaiser Permanente

10. GROSS PREMIUM: $ 420.34

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP:

12. PRIOR PLAN CODE: 2222

13. PRIOR HEALTH PLAN: PERS Choice

14. Permitting Event Code: 4 | 1 | 3

15. Permitting Event Date: Mo. 12 | Day 15 | Year 01

16. EFFECTIVE DATE: Mo. 01 | Day 01 | Year 02

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
		Diane R. Waverly	05	06	58	SELF	
		Dennis T. Waverly	06	05	58	Husb.	

ACTION	CODE	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Relationship	CODE

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 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)
▶ /S/Diane R. Waverly Daytime Phone (916) 555-1212

21. DATE SIGNED: Mo. 12 | Day 16 | Year 01

▶ PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22–27 ◀

22. DEDUCTION PLAN CODE: 0 | 5 | 6

23. Type of action (Check One): 1. ☐ New 2. ☐ Cancel 3. ☑ Change

24. PAY PERIOD: Month 1 | Year 2 | 1

25. PARTY CODE: 2

26. EMPLOYEE DESIGNATION: R

27. BARGAINING UNIT: 01

28. AGENCY NAME (or Retirement System): CalPERS

29. PAYROLL OFFICE CODE: 0

30. AGENCY CODE: 275

31. UNIT CODE: 530

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 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
▶ /S/Carl Edits, Jr.

33. Date received in employing office: Mo. 12 | Day 16 | Yr. 01

34. PHONE NUMBER: (916) 389-1234

35. REMARKS Public Agencies do not complete boxes 22-24
_____ of _____ Forms