

City of Torrance

Health Insurance Enrollment Changes or to Add/Delete Dependents

To change insurance carriers/plans:

There are **three (3)** forms to complete.

- CalPERS Health Benefit Plan Enrollment Form (**must complete**)

[http://www.torranceca.gov/PDF/Health_Benefit_Plan_Enrollment_formHBD-12_\(Rev_8_10\).pdf](http://www.torranceca.gov/PDF/Health_Benefit_Plan_Enrollment_formHBD-12_(Rev_8_10).pdf)

- CalPERS Declaration of Health Coverage HBD-12A (**must complete**)

http://www.torranceca.gov/PDF/CalPERS_Declaration_of_Health_Coverage_HBD-12A.pdf

- City of Torrance Insurance Enrollment/Change Form (**must complete**)

<http://www.torranceca.gov/PDF/InsuranceEnrollmentChangeForm.pdf>

If you elect to use your work zip code you **must complete** an Employer ZIP Code Election form

http://www.torranceca.gov/PDF/CALPERS_Employer_Zip_Code_Election.pdf

If you would like to review a sample of Changing Insurance Carriers enrollment form, click here:

http://www.torranceca.gov/PDF/Sample_2_-_Changing_Insurance_Carriers_Enrollment_Form.pdf

To add/delete dependent coverage:

- CalPERS Health Benefit Plan Enrollment Form (**must complete**)

[http://www.torranceca.gov/PDF/Health_Benefit_Plan_Enrollment_formHBD-12_\(Rev_8_10\).pdf](http://www.torranceca.gov/PDF/Health_Benefit_Plan_Enrollment_formHBD-12_(Rev_8_10).pdf)

- CalPERS Declaration of Health Coverage HBD-12A (**must complete**)

http://www.torranceca.gov/PDF/CalPERS_Declaration_of_Health_Coverage_HBD-12A.pdf

Complete the City of Torrance Insurance Enrollment/Change form **only if you are changing the level of coverage** (Example: Adding one dependent and changing from a Two-party level of coverage to Family level of coverage or deleting one dependent from Family to a Two-party level of coverage). **If the level of coverage remains the same, you don't need to complete this form.**

- City of Torrance Insurance Enrollment/Change Form

<http://www.torranceca.gov/PDF/InsuranceEnrollmentChangeForm.pdf>

If you would like to review a sample of Adding a Dependent enrollment form, click here:

http://www.torranceca.gov/PDF/Sample_1_-_Adding_a_Dependent_Enrollment_Form.pdf

*****Attached are instructions to complete the
Health Benefit Plan Enrollment form HBD-12*****

Instructions for Employees

The table below details the steps you must take to complete the **Health Benefit Plan Enrollment form HBD12**.

Active Employees
Please complete the following boxes 1, 2, 3, 4A, 4B, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 and 21.

NOTE: Please print the Health Benefit Plan Enrollment form HBD12 document when complete. The enrollment form is a PDF file and you will not be able to save the data or document.

Box	Process						
1 Type of Action (required)	<p>Check one:</p> <table border="1"> <tr> <td>New</td> <td>Not enrolled</td> </tr> <tr> <td>Change</td> <td> Is enrolled and either: <ul style="list-style-type: none"> • Changing health plans (when authorized) • Adding family members • Deleting family members • Changing to a Medicare Coordinated plan (at retirement) </td> </tr> <tr> <td>Cancel</td> <td>Canceling all coverage</td> </tr> </table>	New	Not enrolled	Change	Is enrolled and either: <ul style="list-style-type: none"> • Changing health plans (when authorized) • Adding family members • Deleting family members • Changing to a Medicare Coordinated plan (at retirement) 	Cancel	Canceling all coverage
New	Not enrolled						
Change	Is enrolled and either: <ul style="list-style-type: none"> • Changing health plans (when authorized) • Adding family members • Deleting family members • Changing to a Medicare Coordinated plan (at retirement) 						
Cancel	Canceling all coverage						
2 and 3 Social Security Number (required)	Enter your Social Security Number (SSN) and spouse or domestic partner's SSN.						
4A Name and Mailing Address	Enter your name as shown on the appointment document. <i>Do not use nicknames.</i> Enter your RESIDENCE or mailing address.						
4B Residence ZIP Code	Enter a ZIP Code to find an eligibility ZIP Code. If a mailing address is different from the residential address, include the Residence ZIP Code in Box 4B. If you decide to use a work ZIP Code, include that ZIP Code in Box 4A. <p>**If you are choosing to use your work zip code (City of Torrance), please click on the link to complete Employer Zip Code Election form. This must be complete and turned into Human Resources along with your enrollment form.</p> <p>http://www.torranceca.gov/PDF/CALPERS_Employer_Zip_Code_Election.pdf</p>						
5 Permanent Intermittent (State/CSU employees only)	Box 5 is not applicable to City of Torrance employees. Skip to Box 6 and 7.						
6 and 7 Gender and Marital Status	Check the appropriate box: Yes- if married or separated No- if unmarried or received a final divorce decree						

8 and 9
Plan Code and
Health Plan

Enter the correct plan code and the name of the health plan.
Plan Name and Plan Code to use for Box 8, 9, 12, & 13

LA County

	1-Party	2-Party	Family
Plan Name	Plan Code	Plan Code	Plan Code
Anthem Select HMO	4131	4132	4133
Anthem Traditional HMO	4021	4022	4023
Blue Shield NetValue Advantage	062	1452	1453
Blue Shield Advantage (Access +HMO)	1441	1442	1443
Health Net Salud y Mas	4431	4432	4433
Health Net SmartCare	4081	4082	4083
Kaiser	3061	3062	3063
United Healthcare	4281	4282	4283
PERS Choice	3211	3212	3213
PERS Care	3261	3262	3263
PERS Select	0801	0802	0803
PORAC*	2071	2072	2073
*Fire and Police sworn personnel only			

Other S. California
Region

	1-Party	2-Party	Family
Plan Name	Plan Code	Plan Code	Plan Code
Anthem Select HMO	4781	4782	4783
Anthem Traditional HMO	4071	4072	4073
Blue Shield NetValue Advantage	0641	0642	0643
Blue Shield Advantage (Access +HMO)	1421	1422	1423
Health Net Salud y Mas	4121	4122	4123
Health Net SmartCare	4141	4123	4124
Kaiser	3081	3082	3083
United Healthcare	4321	4322	4323
PERS Choice	3231	3232	3233
PERS Care	3281	3282	3283
PERS Select	0821	0822	0823
PORAC*	2071	2072	2073
*Fire and Police sworn personnel only			

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Using the applicable **Open Enrollment rate sheet**, enter the full gross

Gross Premium	premium as shown in <i>dollars</i> and <i>cents</i> . This is the PERS rate.										
11 Primary Care Physician	For HMO selected plans. Enter the name of a primary care physician and/or provider group. If you select an HMO but do not designate a Primary Care Physician/Provider Group, the plan will select one for you. To select a primary care physician, log into: https://www.blueshieldca.com/bsc/calpers/member/find-provider/index.jhtml										
12 and 13 Prior Plan Code, Prior Health Plan	Enter this information only if you are changing plans or canceling coverage. See Plan Name and Plan Code information above.										
14 Permitting Event Code (Reason Code)	Enter the appropriate transaction code which applies: <table border="1" data-bbox="397 514 1209 682"> <tr> <td>104</td> <td>New Enrollment during Open Enrollment</td> </tr> <tr> <td>206</td> <td>Adding Dependent during Open Enrollment</td> </tr> <tr> <td>320</td> <td>Open Enrollment Delete Dependent</td> </tr> <tr> <td>400</td> <td>Changing Plans during Open Enrollment</td> </tr> <tr> <td>530</td> <td>Open Enrollment Cancel Coverage</td> </tr> </table>	104	New Enrollment during Open Enrollment	206	Adding Dependent during Open Enrollment	320	Open Enrollment Delete Dependent	400	Changing Plans during Open Enrollment	530	Open Enrollment Cancel Coverage
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320	Open Enrollment Delete Dependent										
400	Changing Plans during Open Enrollment										
530	Open Enrollment Cancel Coverage										
15 Permitting Event Date (required)	Enter the date of an event that permits a change. If you are making changes during open enrollment the date should be during the open enrollment period. (Example: Open Enrollment period September 13, 2010 to October 7, 2010). Another Example: The employee's appointment date, the date of marriage or divorce, the date of death, or the birth date of a dependent.										
16 Effective Date Permissive and Mandatory Transactions	Mandatory transactions For Open Enrollment transactions, the date would be the beginning of the next calendar year. (Example: Effective Date January 1, 2011 for open enrollment dates of September 13, 2010 to October 7, 2010). Permissive transactions are effective on the first of the month following the date the agency receives an enrollment form (Box 33), within 60 days of event. For all others the effective on the first of the month following an event (Box 15).										
17 and/or 18 Enrolled Family Members	Use the appropriate Action Code to indicate <i>additions</i> or <i>deletions</i> of family members. NOTE: If you need additional space for dependents, complete the form, print the document, then delete the other dependents and add the additional dependents. Print the document and staple it together and submit to Human Resources. <table border="1" data-bbox="389 1617 1339 1837"> <thead> <tr> <th>Action Code</th> <th>Procedure</th> </tr> </thead> <tbody> <tr> <td>A</td> <td>Use A to indicate the addition of family member(s), such as a new enrollment; mark the <i>Action Code</i> to the left of each enrollee's name</td> </tr> <tr> <td>D</td> <td>Use D to indicate the deletion of family member(s)</td> </tr> </tbody> </table> <p>Note: Do not use <i>Action Codes</i> to change plans or to cancel coverage (use boxes 1 and 19 to change plans or cancel coverage).</p> <p>When adding or deleting dependents, place an <i>Action Code</i> next to their</p>	Action Code	Procedure	A	Use A to indicate the addition of family member(s), such as a new enrollment; mark the <i>Action Code</i> to the left of each enrollee's name	D	Use D to indicate the deletion of family member(s)				
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D	Use D to indicate the deletion of family member(s)										

name(s), then list additional family members names that are already covered but **do not add** an *Action Code*).

List all family members as follows (avoid nicknames):

- First name (full)
- Middle (abbreviation)
- Last name (full)
- List birthdate(s) as: MM/DD/YYYY
- List Social Security Numbers for dependents (**required**).

Abbreviations for *family relationship codes*:

Family Relationships	Abbreviation
Wife	Wife
Husband	Husb
Son	Son
Daughter	Dtr
Stepson	S/Son
Stepdaughter	S/Dtr
Adopted Son	A/Son
Adopted Daughter	A/Dtr
All Others	Specify

Note: A Family Code is not required.

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Check One

I do not wish to enroll	Check this box <i>only</i> when you wish to decline Health Benefits coverage.
I elect to enroll	Check this box for new enrollments and enrollment changes.
I elect to cancel	Check this box only for cancellation of all coverage, including "self." Do not check this box when deleting a family member.

20
Employee or Annuitant Signature

You **must sign** the Health Benefit Plan Enrollment Form.

By doing so you:

- Authorize premium deductions
- Verify a health plan selection
- Verify the eligibility of all enrolled family members
- Please include a daytime phone number

21
Date Signed

Enter the month, day, and year. **If you are making changes during open enrollment the date signed should be during the open enrollment period. (Example:** Open Enrollment period September 13, 2010 to October 7, 2010).

Remember: *Permissive enrollment transactions are valid only when they are received in the Human Resources office and dated within 60 calendar days from the event date.*

Please print this document when complete. You will not be able to save the data or document. Submit completed document to Human Resources.

Box 22-35

Employer Completes