



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

SAMPLE
 Adding A Dependent

CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER

HEALTH BENEFIT PLAN
 ENROLLMENT FORM **DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS**
 PERS-HBD-12 (Rev.8/10)

PLEASE TYPE

1. TYPE OF ACTION (Check One)		2. SOCIAL SECURITY NUMBER 777 — 77 — 7777		A C C T I O N	LIST ALL PERSONS (including self) TO BE ENROLLED IN:			DATE OF BIRTH			Family Relationship		G E N D E R		C O D E	
<input type="checkbox"/> a. NEW enrollment <input checked="" type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage		3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER 222 — 22 — 2222			17. BASIC PLAN			Mo. Day Yr.					M F			
					(FIRST) (MI) (LAST) John M. Doe			02 05 50			SELF		<input checked="" type="checkbox"/> <input type="checkbox"/>			
4A. Name John M. Doe				SSN 777-77-7777												
Mailing Address (FIRST) (MI) (LAST) 1201 Anywhere Lane				(FIRST) (MI) (LAST) Jane C. Doe				05 01 53			Wife		<input type="checkbox"/> <input checked="" type="checkbox"/>			
City, State, ZIP Torrance, CA 90503				Daytime Phone (310) 111-1111		Evening Phone (310) 222-2222		SSN 222-22-2222								
4B. RESIDENCE ZIP CODE (If different from 4A)				A (FIRST) (MI) (LAST) Joanne F. Doe				09 09 10			Dtr		<input type="checkbox"/> <input checked="" type="checkbox"/>			
5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only)		6. GENDER <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		7. MARRIED <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		SSN 333-33-3333										
8. PLAN CODE 0623		9. NAME OF HEALTH PLAN Blue Shield NetValue		SSN												
10. GROSS PREMIUM \$ 1,111.71		11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP Dr.Smith-Family Doctor Center/0101012														
12. PRIOR PLAN CODE 0622		13. PRIOR HEALTH PLAN Blue Shield NetValue		A C C T I O N				18. SUPPLEMENTAL PLAN			DATE OF BIRTH			Relation-ship		C O D E
								(FIRST) (MI) (LAST)			Mo. Day Yr.					
14. Reason Code 206		15. Permitting Event Date Mo. Day Yr. 09 13 2010		16. EFFECTIVE DATE Mo. Day Yr. 01 01 2011												

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)
John M. Doe
 TELEPHONE NUMBER (310) 222-2222

21. DATE SIGNED
 Mo. 09 Day 15 Year 2010

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. <input type="checkbox"/> New 2. <input type="checkbox"/> Cancel 3. <input type="checkbox"/> Change	24. PAY PERIOD Month Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
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28. AGENCY NAME (or Retirement System) City of Torrance	29. PAYROLL OFFICE CODE 5	30. AGENCY CODE 0158	31. UNIT CODE
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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 or 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		