



**Health Benefit Services Division**  
 P.O. Box 942714  
 Sacramento, CA 94229-2714  
 Telecommunications Device for the Deaf - (916) 326-3240  
 Toll Free: (800) 237-3345 Fax: (916) 326-3935

## EMPLOYER ZIP CODE ELECTION

1. I am employed by \_\_\_\_\_  
Name of Employer

My employer's address is:

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

ZIP Code: \_\_\_\_\_

I elect to enroll in \_\_\_\_\_ plan ("Plan") based on its servicing of an area  
Name of HMO  
 that includes my work address.

2. I understand that unless I obtain Plan pre-approval, I and my enrolled family members must receive non-emergency care from physicians and facilities within the Plan's service area, and that in not doing so I understand that I will incur out-of-pocket costs.

3. I understand that if I am an active member I need to file this Election with my employer's Health Benefits Officer. If I am a working retiree, I need to mail this Election to CalPERS at the address listed below:

CalPERS  
 Health Benefits Services Division  
 P.O. Box 942714  
 Sacramento, CA 94229-2714

My Name: \_\_\_\_\_  
Please print

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_