Health Benefits Plan Enrollment for Retirees

888 CalPERS (or **888**-225-7377) • TTY (877) 249-7442 • Fax (800) 959-6545

For Retirees only. (Active employees - contact your Personnel Office).
To save time, complete this form before you request changes over the phone.

Section 1 — Type of Change

Check the type of change you are making.

- ☐ Change My Health Plan
- ☐ Enroll in a Health Plan
- ☐ Add Eligible Dependents to My Health Plan
- ☐ Open Enrollment (Check this box if the requested change is due to Open Enrollment)

You can make changes by calling **888 CalPERS** (or **888**-225-7377), by faxing this form to us at (800) 959-6545, or by visiting my|CalPERS at **my.calpers.ca.gov**.

Section 2 — Retiree Information

Be sure to include the name of the agency from which you retired.

If you are enrolled in Medicare, please send a copy of your Medicare card.

Name (First Name, Middle Initial, Last Name) | Social Security Number (- -)

Birthdate (mm/dd/yyyy) | Gender | Daytime Phone ( ) | Evening Phone ( )

Address | County (residence)

City | State | Zip

Retirement Date (mm/dd/yyyy) | Name of Former Employer

Section 3 — Health Plan

Before requesting a plan change, verify that the doctor you want is contracted with the health plan and is accepting new patients. If not, you will need to find another doctor who contracts with the new plan

Name of New Health Plan | Name of Doctor/Medical Group (include ID #s, if known)

Section 4 — Dependent Information

All dependents currently enrolled on your health plan will remain on your plan.

List only the dependents you are adding. If you have more than 3 dependents, please include on a separate page.

Dependent Name | Social Security Number (- -) | Birthdate (mm/dd/yyyy)

Relationship | Gender | Doctor or Medical Group

Dependent Name | Social Security Number (- -) | Birthdate (mm/dd/yyyy)

Relationship | Gender | Doctor or Medical Group

Dependent Name | Social Security Number (- -) | Birthdate (mm/dd/yyyy)

Relationship | Gender | Doctor or Medical Group

Put your name and Social Security number at the top of every page.

Your Name | Social Security Number

Section 5 Retiree Signature

Please be sure to sign this form.

By signing this form, I elect to change the plan indicated above and/or add eligible family members. I also certify that the health information listed above is true and complete and authorize deductions, if applicable, to be made from my retirement allowance to cover my share of the health plan premium.

Signature of Retiree | Date

Section 6 Additional Information

You can submit your health plan changes by mail, by phone, or by fax.

After making changes to your health plan, be sure to examine your retirement check to verify that the proper deduction was made. If the deduction is incorrect, call CalPERS to report the discrepancy.

Health Benefits Plan Enrollment for Retirees

Use this form to enroll in a health plan, change your plan, or add an eligible dependent(s) to your plan if you meet all of the following requirements:

- Are eligible for enrollment on the date of separation
- Retired within 120 days from the day you separated from your job
- Are receiving a retirement check

Contact CalPERS with any eligibility questions.

Notes

- Any health plan changes made during Open Enrollment become effective the following January 1.
- You can use this form to make changes to your health plan outside of Open Enrollment due to a qualifying event, such as adding a new spouse, registered domestic partner, or dependent child.
  - Adding a spouse requires a copy of your marriage license
  - Adding a registered domestic partner requires a copy of the approved *Declaration of Domestic Partnership*
  - Adding a dependent child you have assumed a "parent-child relationship" with, requires an ***Affidavit of Parent Child Relationship***
- Be sure to report changes to CalPERS in a timely manner to avoid retroactive reimbursement liability.
- If you are enrolled in a Medicare Managed Care plan (Medicare Advantage) and are switching to a Supplement to Medicare plan, you must contact your current health plan or the nearest Social Security Administration office to disenroll your Medicare benefits from you current Medicare Managed Care plan. If you do not disenroll, Medicare will not pay for services you receive under your new health plan.
- If any one of your dependents is enrolled in Medicare, please send a copy of the Medicare card.

Mail to: California Public Employees' Retirement System P.O. Box 942715, Sacramento, CA 94229-2715

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www.calpers.ca.gov

California Public Employees' Retirement System

Certification of Medicare Status

Please complete **Section 1**, and either **Section 2, 3** or **4.** Sign and date the form and return it to CalPERS at P.O. Box 942715, Sacramento, CA 94229-2715.

Section 1: Please enter the Member's/Dependent's name and CalPERS ID.

CalPERS Retiree Name:	**CalPERS Retiree CalPERS ID:**
Medicare-Eligible Member/Dependent:	**Member/Dependent CalPERS ID:**

Section 2: For Member/Dependent Enrolled in Medicare Part A and B

☐ I am enrolled in Medicare Part A and Medicare Part B. This is the information reflected on my red, white and blue Medicare card or Notice of Entitlement from the Social Security Administration:

Name of Medicare Beneficiary:

Medicare Claim Number: _____

HOSPITAL (PART A) effective date: _____

MEDICAL (Part B) effective date: _____

Section 3: For Member/Dependent claiming Medicare Ineligibility

☐ I am not eligible for premium-free Medicare Part A (in my own right or through the work history of a current, former or deceased spouse). I have verified this with the Social Security Administration and have attached documentation of this fact.

Section 4: For Member/Dependent who works and has Employer Group Health Plan Coverage

☐ I have deferred Medicare Part B enrollment due to working beyond age 65 and have coverage in my/ my spouse's Employer's Group Health Plan and have attached documentation of this fact.

1. Name of your current employer
2. Name of your Group Health Plan provided by your employer

_____

Section 5: Member/Dependent Signature

I certify that the above information is true and correct.

_____ _____

Signature Date (mmddyyyy)

_____

Daytime telephone number

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