CalPERS

PERS USE ONLY DOCUMENT REFERENCE NUMBER

GROUP CONTINUATION COVERAGE
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT "COBRA"
PERS-HBD-85 (Rev 6/13)

Public Employees' Retirement System
Health Account Services
P.O. Box 942715
Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377)
TTY (877) 249-7442 Fax (800) 959-6545

INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE REVERSE SIDE. *PLEASE TYPE*

PART A: ORIGINAL QUALIFYING EVENT AND DATES

1. Type of Action
☐ NEW
☐ CHANGE

2. QUALIFYING EVENT
☐ EMPLOYMENT SEPARATION TIME BASE REDUCTION
☐ DIVORCE/LEGAL SEPARATION
☐ CHILD CEASES TO BE A DEPENDENT
☐ DEALTH OF AN EMPLOYEE/RETIREE
☐ DEPENDENT CONTINUATION-ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE

3. EVENT DATE

4. COBRA ENROLLMENT PERIOD
FROM 01
TO

PART B: ENROLLEE INFORMATION

5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER)
SOCIAL SECURITY NUMBER ___ ___
NAME
ADDRESS
CITY, STATE, ZIP
DAY PHONE ( )
MARRIED ☐ YES ☐ NO
BIRTHDATE
SEX ☐ MALE ☐ FEMALE

6. SUBSCRIBER (EMPLOYEE/RETIREE)
SOCIAL SECURITY NUMBER ___ ___
NAME

PART C: CARRIER INFORMATION

7. NAME AND ADDRESS OF HEALTH PLAN

PLAN CODE: _____ PREMIUM: $ _____
PHONE:

PART D: DEPENDENT INFORMATION

ACTION CODE	LIST OF ALL PERSONS (including self) TO BE ENROLLED: (FIRST) (MI) (LAST)	DATE OF BIRTH MO. DAY YR	FAMILY RELATIONSHIP
	SSN		
	(FIRST) (MI) (LAST)		**SELF**
	SSN		
	(FIRST) (MI) (LAST)		
	SSN		
	(FIRST) (MI) (LAST)		
	SSN		

PART E: ENROLLMENT CHANGES

9. NAME OF PRIOR HEALTH PLAN
10. PRIOR PLAN CODE
11. PERMITTING EVENT CODE
12. PERMITTING EVENT DATE
13. EFFECTIVE DATE OF CHANGE 01

PART F: SIGNATURE OF ENROLLEE

14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.

SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION)

DATE SIGNED

PART G: AGENCY INFORMATION

15. AGENCY NAME _____
AGENCY CODE _____ UNIT CODE _____

16. HEALTH BENEFITS OFFICER'S SIGNATURE
DATE RECEIVED _____ PHONE _____

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information is collected pursuant to the Government Code Sections (20000 et. seq) and will be used for administration of the Board's duties under the California Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another government agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

INSTRUCTIONS FOR THE COMPLETION OF THE FORM HBD-85 (08/2011)

Part A
1. Type of Action check " NEW " if this is a new enrollment.
   Check " CHANGE " if family member is added, deleted, or any plan changes.
2. Check applicable Original Qualifying Event and Dates.
3. Provide original event date (separation, date of divorce, etc.).
4. Original COBRA enrollment period.
   Examples:
   Separation from enrollment 4-15-2010 (Perm. Event) FROM 6-1-2010 TO 11-30-2011
   Child attains age 26 on 6-15-2010 (Perm. Event) FROM 7-1-2010 TO 6-30-2013

Part B: 5. Please provide all requested information.

6. If the COBRA enrollee is a former dependent, the employee/retiree must be identified in box 6.

Part C: 7. Please identify the carrier. The COBRA enrollee must continue the same coverage which he or she had as an employee or as a dependent. Carrier changes are only allowed during the Open Enrollment period or if the enrollee moves into or out of a carrier's geographic service area. The carrier's name, address, and phone number can be found in the annual Health Benefit Summary which is available in all employing agencies. The monthly premium may not exceed 102% of the group rate.

Part D: 8. List all family members to be enrolled, including self.

Action Code: Use "A" to indicate which person is being added (or newly enrolled). Use "D" to indicate if an individual is being deleted from an existing COBRA enrollment. An Action Code is not required when changing carriers.

IMPORTANT: The addition or deletion of family members is regulated by time limits which are identical to those for active enrollees (subscribers).

Part E: 9-10 Name and Plan Code of prior health plan if COBRA coverage is being changed.

10-13 to be completed by the Health Benefits Officer

Part F: 14. Signature of COBRA enrollee and date signed.

Part G: 15-16: To be completed by the (former) employing agency. For (former) dependents of retirees, CalPERS is the "employing agency".

IMPORTANT: It is the responsibility of the COBRA enrollee to report enrollment changes in a timely manner. Enrollment change requests must be submitted in accordance with existing regulations, laws, and the time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Part G.