CalPERS HEALTH BENEFITS RETIREE ENROLLMENT FORM

PA

TO ENROLL, COMPLETE AND RETURN THIS FORM TO:
Health Account Services
P.O. Box 942714, Sacramento, CA 94229-2714
OR SUBMIT BY FAX: (916) 795-1313

(888) CalPERS (or **888**-225-7377) | TTY: (916) 795-3240
www.calpers.ca.gov

Member SSN

______ - _____ - ______

Agency Code and Name: **4628924879** **Foothill-De Anza Community College District**	**Group/Bargaining Unit:**	**Retirement System:**

Name of Retiree/Member:
First   Middle   Last

Mailing Address:
Number & Street ______________________________
____
City, State, Zip ______________________________

Sex: ❑ Male ❑ Female
Married: ❑ Yes ❑ No
Date of Birth: ___/___/___

Please select your enrollment effective date:
❑ January 1, 2013

Name of CalPERS Health Plan Selection: ______________________________

Primary Care Physician/Medical Group: ______________________________

All persons to be enrolled in the health plan:

Name	Social Security No.	Date of Birth	Relationship	Type of Coverage*
______________	_____-___-_____	___/___/___	_SELF___	❑ Basic ❑ Medicare
______________	_____-___-_____	___/___/___	_________	❑ Basic ❑ Medicare
______________	_____-___-_____	___/___/___	_________	❑ Basic ❑ Medicare

*NOTE: To enroll in a CalPERS Medicare-coordinated health plan, persons must be enrolled in Medicare Part A and Part B. **A copy of a Medicare card and/or *Certification of Medicare Status* form must be provided for every Medicare-eligible person. Please submit with this enrollment form.**

- ❑ Enclosed is a copy of my Medicare card or *Certification of Medicare* Status form.
- ❑ I am not eligible for Medicare. Attached is evidence of this fact.
- ❑ Enclosed is a copy of my dependent's Medicare card or *Certification of Medicare Status* form.
- ❑ My dependent is not eligible for Medicare. Attached is evidence of this fact.

❑ **I DO NOT WISH** TO ENROLL IN A PLAN UNDER THE ACT

❑ **I ELECT TO ENROLL** IN A HEALTH BENEFITS PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY 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 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED IN THE PUBLIC EMPLOYEES MEDICAL AND HOSPITAL CARE ACT.

Signature	**Date**	**Daytime Phone Number**

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

Your Name	Social Security Number
	- -

Section 5 Retiree's Signature

Please be sure to sign this form.

By signing this form, I elect to change to 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. All changes are subject to verification of eligibility. You are eligible to enroll in a CalPERS health 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 life event, such as adding a new spouse, registered domestic partner, or economically 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 child where a parent-child relationship exists requires an Affidavit of Parent-Child Relationship form (HBD-40).
- 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 your 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: CalPERS Office of Employer & Member Health Services • P.O. Box 942714, Sacramento, California 94229-2714