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

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:
❑ July 1, 2012 ❑ August 1, 2012 ❑ September 1, 2012

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**