West Valley - Mission Community College District

2017 CalPERS Health Benefits Enrollment Instructions

Please complete the attached form as well as the HBD-12A.

Section	Special Notes
A	Please provide your social security number, full name, and date of birth. If you are married or in a domestic partnership, please mark "Yes" for "Married" and please provide the date of the marriage or partnership. If you are requesting coverage for your spouse/partner, you must submit a copy of the Marriage License or Declaration of Domestic Partnership that is on file with the Secretary of State.
B	Your residence address must NOT be a PO box, but a physical address. If you like, you may provide a separate mailing address.
C	Contact information. Please select how you prefer to be contacted, either phone or email. Please provide both a phone number and an email address.
D	Your Medical Benefit plan choices can be determined either by your place of residence or by your place of work. Please specify the Qualifying Address you wish to use to determine your medical benefit plans. Select the appropriate CalPERS Health Benefit Plan. For specific details on the plans, please refer to the Benefits Overview Guide. NOTE: If you select an HMO, please name the Primary Care Physician. If you do not designate a Primary Care Physician/Medical Group, the plan will select one for you.
E	If you are requesting coverage for dependents, you will need to supply social security number, name, date of birth, gender, and the dependent's relationship to you (e.g. child by birth, adopted child, stepchild, spouse). For all dependents, additional documentation is required. See the checklist below to determine what documentation you will need to supply.
F	Please specify whether you are accepting or declining Health Benefits Coverage and then sign and date this form.

Both pages of this form, along with all required supporting documentation, must be delivered to Human Resources within 30 days of your hire date or life event date. Required documentation includes:

- ☐ To cover a spouse – provide the date of the union and a copy of the Marriage Certificate
- ☐ To cover a domestic partner – provide the date of the union and a copy of the Declaration of Domestic Partnership that is on file with the Secretary of State
- ☐ To cover your children or your spouse's children or your domestic partner's children – provide a copy of the Birth Certificates/Adoption papers for dependents under 26 years of age
- ☐ To cover children under 26 years of age who live with you and for whom you are caring for the child as a parent would (defined as a parent/child relationship) – complete and provide a copy of the Affidavit of Parent-Child Relationship Form (CalPERS Form HBD-40, available at www.calpers.ca.gov)
- ☐ To cover dependents over the age of 26 who are incapable of self-support due to a mental or physical condition that existed prior to age 26 – complete and provide a copy of the Questionnaire for Disabled Dependent Benefits (CalPERS form HBD-98, available at www.calpers.ca.gov) **AND** ask your physician to complete a Medical Report for the CalPERS Disabled Dependent Form for you to return to Human Resources (CalPERS form HBD-34, available at www.calpers.ca.gov).
- ☐ A completed and signed CalPERS HBD-12A form

West Valley - Mission Community College District

2017 CalPERS Health Benefits Enrollment

CalPERS

All fields with an asterisk (*) must be completed before submitting this form to Human Resources.

A

Social Security Number *

Last Name *

First Name *

Middle Name

Date of Birth *

Gender * ◯ Female ◯ Male

Married * ◯ Yes ◯ No

Date of Marriage/ Partnership *

B

Please enter your residential address (this must NOT be a PO Box).

Residence Address *

Address (Line 2)

City *

State *

Zip Code *

If you have a different mailing address, please enter it here.

Mailing Address

Address (Line 2)

City

State

Zip Code

C

Please provide contact information.

Preferred Contact * ◯ Phone ◯ Email

Phone Number *

Email *

D

Specify your qualifying address and select your plan. If you selected an HMO, designate your Primary Care Physician.

Qualifying Address for Benefit Plans * ◯ Residence ◯ Work

CalPERS Health Plan *

- ◯ Anthem Blue Cross Select HMO
- ◯ Anthem Blue Cross Traditional HMO
- ◯ Blue Shield Access+ HMO
- ◯ HealthNet SmartCare HMO
- ◯ Kaiser Permanente HMO
- ◯ UnitedHealthcare SignatureValue Alliance HMO
- ◯ PERS Choice PPO
- ◯ PERS Select PPO
- ◯ PERSCare PPO
- ◯ PORAC PPO (Association Plan)

Primary Care Physician (for HMO Plans only)

This Section to be completed by WVMCCD Human Resources Department.

CalPERS ID

Permitting Event Date *

Effective Date *

Qualifying Retirement Plan * ◯ PERS ◯ STRS

Bargaining Unit *

Hire Date *

List each additional family member to be enrolled in health benefits (all fields are required for each enrolled dependent). If you have additional dependents, please submit an additional copy of this page.

Social Security Number *

Last Name *

First Name *

Middle Name

Date of Birth *

Gender * ◯ Female ◯ Male

Relationship to Employee *

Social Security Number *

Last Name *

First Name *

Middle Name

Date of Birth *

Gender * ◯ Female ◯ Male

Relationship to Employee *

E

Social Security Number *

Last Name *

First Name *

Middle Name

Date of Birth *

Gender * ◯ Female ◯ Male

Relationship to Employee *

Social Security Number *

Last Name *

First Name *

Middle Name

Date of Birth *

Gender * ◯ Female ◯ Male

Relationship to Employee *

EMPLOYEE MUST SELECT ONE OPTION AND SIGN BELOW:

◯ I do NOT elect to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.

F

◯ I elect to enroll in the Health Benefits Plan as chosen on the reverse side of this form and authorize deductions to be made from my salary or 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.

Employee Signature

Date

I hereby certify under penalty of perjury as follows: That I am a duly appointed, qualified and acting officer of the above named agency and that payment by the agency as provided by Sections 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act.

Signature of HR Rep

Date Received