Health Benefits Plan Enrollment for Active Employees (HBD-12) Instructions

Contact your agency's personnel office if you have questions about your health enrollment. To enroll or decline enrollment in the CalPERS Health Program or to make changes to your health plan, you must submit an HBD-12 form to your Health Benefits Officer (HBO). If you have more than five dependents, please complete another HBD-12 form. Your agency's personnel office will retain your original HBD-12 form and supporting documentation or affidavits in your employee file and will provide a copy to you.

SECTION A: Applicant Information

Enter your basic information as indicated. If you are using your work zip code for health eligibility, please include your work zip code in part 8.

SECTIONS B & C: Type of Action and Type of Permitting Event

Select the the type of action and your permitting event. Below is a list of permitting events and required documentation. The required documents in the table below are not inclusive; you may need to submit additional documentation upon your HBO's request.

Permitting Event	Required Documentation
New Employee	• Health Benefits Plan Enrollment Form (HBD-12)
New Contracting Agency	• Health Benefits Plan Enrollment Form (HBD-12)
Marriage or Domestic Partnership	• Marriage Certificate or • Declaration of Domestic Partnership from the Secretary of State's Office
Delete Dependent Due to Death	• Death Certificate
Divorce or Domestic Partnership Termination	• Divorce Decree or • Termination of Domestic partnership submitted to the Secretary of State's Office
Move	• New address - Please provide your new address to your agency's personnel office
Birth/Adoption	• Birth Certificate/Adoption Paperwork
Open Enrollment	• Health Benefits Plan Enrollment Form (HBD-12)

SECTION D: Subscriber and Dependent Information

List yourself and other dependents and the actions you are requesting (add or delete). Use the relationship codes to identify the type of dependents.

SECTION E: Enrollment

To enroll in a CalPERS health plan, you must review the information and check the box in part 16. To decline enrollment in a CalPERS health plan, you must review the information and check the box in part 17. Sign and date the form in parts 18 and 19.

SECTIONS F & G: CalPERS Privacy Notices

Please review these important privacy notices.

SECTION H: Employer Use Only

Your agency's personnel office will complete this section.

More Information

You can obtain health benefits publications, required forms, and other information about your CalPERS health benefits through our website at **www.calpers.ca.gov** or by calling CalPERS at **888 CalPERS** (or **888**-225-7377).

Health Account Management Division
P.O. BOX 942715
Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545
www.calpers.ca.gov

Health Benefits Plan Enrollment for Active Employees (HBD-12)

SECTION A: Applicant Information

1. Employee Name: *(First)* *(M.I.)* *(Last)* **2. Hire Date:** (mm/dd/yyyy)

3. CalPERS ID or Social Security Number: **4. Date of Birth:** *(mm/dd/yyyy)* **5. Gender:** ☐ Male ☐ Female ☐ Nonbinary

6. Physical Address: *(Street)* *(City)* *(State)* *(ZIP)* *(County)*

7. Mailing Address (If different): *(Street)* *(City)* *(State)* *(ZIP)* *(County)*

8. Use Work ZIP Code for Health Eligibility: ☐ Yes ☐ No *If yes, enter zip code here: (ZIP)*

9. E-mail Address: **10. Primary Phone:** **Alternate:**

SECTION B: Type of Action

11. ☐ Enroll in a Health Plan ☐ Add/Delete Dependents ☐ Change Health Plan ☐ Cancel All Coverage ☐ Decline Coverage

SECTION C: Type of Permitting Event

12. ☐ New Employee ☐ New Contracting Agency ☐ Marriage or Domestic Partnership Date *(mm/dd/yyyy)*: ☐ Open Enrollment ☐ Move
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/ Adoption ☐ Other:

13. Permitting Event Date: (mm/dd/yyyy) **14. Name of Health Plan**: (If changing health plans, list new plan name)

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents)

15. Name (First, M.I., Last)	Relationship Code *1	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF	☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	

*1 **Relationship Codes:** **S** - Spouse **DP** - Domestic Partner **NC** - Natural Child **SC** - Step Child **AC** - Adopted Child **DPC** - Domestic Partner Child **PCR** - Parent Child Relationship

SECTION E: Enrollment

16. To enroll, carefully review the information in this section and check the box:

☐ **I ELECT TO ENROLL** in (or **MAKE CHANGES TO**) a health benefits plan as indicated above and agree to authorize deductions from (1) my salary to cover my share of the cost of enrollment as it is now or as it may be in the future (2) my retirement allowance to continue health benefits coverage into retirement. **I CERTIFY** that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. **I AGREE** to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

17. To decline, carefully review the information in this section and check the box:

☐ **I DECLINE ENROLLMENT** into the CalPERS Health Program for myself and my dependents.

I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the 90 day waiting period or the OE effective date.

18. Employee Signature: EE Payroll Number: **19. Date:** *(mm/dd/yyyy)*

SECTION F: CalPERS Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose
The information requested is collected pursuant to the Government Code Sections (20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to perform its functions regarding your status.

Please do not include information that is not requested.

SSN
Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction / state contributions
3. Billing of contracting agencies for employee / employer contributions
4. Reports to the CalPERS system and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals, complaints, or grievances with health plan carriers

Information Disclosure
Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights
You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy, or your rights, please write the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call our Customer Contact Center at 888-CalPERS (888-225-7377).

SECTION G: Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the 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 other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, change of address, marriage, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

SECTION H: For Employer Use

Please retain original signed form and all supporting documentation or affidavits in employee file. DO NOT send to CalPERS.

20. **Agency Name:** County of Santa Cruz	21. **Date of Hire**: *(mm/dd/yyyy)*	22. **Retirement System**: ☒ CalPERS ☐ CalSTRS ☐ Other
23. **CalPERS Employer ID:** 54680801525	24. **Division ID:** Benefits	25. **Employee Bargaining Unit/Employee Group:**
26. **Payroll Office:** ☐ State Controller's Office ☐ Non Central ☒ Public Agency Billing	27. **Date Received by Employer:**	28 **Effective Date:** *(mm/dd/yyyy)*

I hereby certify under the penalty of perjury that I am a duly appointed, qualified and acting Health Benefits Officer (HBO) of the above named agency, and the payment by the agency as provided by Section 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 and the regulations implementing the Act.

29. **Health Benefits Officer Signature/Date:)**	30. **Health Benefits Manager Signature:**	31. **Date:** *(mm/dd/yyyy)*	32. **Phone Number:** (831) 454-2600

33. **Remarks:**

County of Santa Cruz
Dental and Vision Enrollment Form

Employee Name:_____ Social Security Number:_____

Mailing Address:_____ Payroll Number:_____

City, State, Zip:_____ Married: ☐ Yes ☐ No

Email Address:_____ Gender: ☐ Male ☐ Female ☐ Non-Binary

Dental (3 plan options)

☐ Delta Preferred Option *(Basic PPO Option, No Cost)*

☐ Delta DPO+ *(Buy-Up PPO Option, $24 per pay period)*

☐ Cigna Dental Care Access *(DHMO, No Cost)*

Vision (1 plan option)

☐ VSP Employee Vision *(No Dependents, No Cost)*

☐ VSP Dependent Vision *($8.92 per pay period)*

Dependent(s) Name First, MI, Last	Social Security Number xxx-xx-xxxx	Date of Birth mm/dd/yyyy	Family Relationship (Spouse, Child etc.)	Gender (M, F, NB)	Add Dental	Add Vision	Delete Dental	Delete Vision

H-Care Participants: H-Care (Medical Premium Pre-Tax Program) participants have their medical cost deducted from their income on a pre-tax basis each pay period. These participants are also eligible to have their costs for Delta DPO+ and Dependent Vision added to their medical cost on a pre-tax basis each pay period.

You must have an H-Care Enrollment Form on file and be enrolled in a County medical plan to participate. If you are not enrolled in H-Care and a County medical plan, these options do not apply to you.

H-Care Selection: Choose an option that applies to the dental and vision selection made above.

☐ Option 2: Medical and VSP Dependent Vision

☐ Option 3: Medical and Delta DPO+ Dental

☐ Option 4: Medical and Delta DPO+ Dental and VSP Dependent Vision

- I understand and authorize the additional costs for enrolling in Delta DPO+ and/or Dependent Vision, are added to the medical cost and deducted from my income on a pre-tax basis each pay period.
- Due to the tax implications of this pre-tax program, I understand that I must remain enrolled in Delta DPO+ and/or Dependent Vision for the entire plan year*.

*H-Care enrollment remains in effect for the entire plan year. If the employee goes on an unpaid status, the enrollment terminates. The employee can re-enroll in this pre-tax program during open enrollment.

Employee Signature | Primary Phone Number | Date

Office use:

On file: _Marriage _DP _Birth _SSN _Other Notes:

Permitting Event Date	Effective Date	HBO Rec'd Date	Bargaining Unit	HBO Initials	Supervisor Approval

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

BENEFICIARY DESIGNATION

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer:		Policy Number:

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)