

Public Employees' Retirement System Post Office Box 942714 Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN ENROLLMENT FORM

DO NOT SEND MEDICAL

PERS LISE ONLY-DOCUMENT REFERENCE NUMBER

PERS—HBD-12 (Rev. 10/93) CLAIMS TO THIS ADDRESS PERS USE ONLY—DOCUMENT REFERENCE NUMBER											
		PLEASE	_	1						_	
1. TYPE OF ACTION	2. SOCIAL SECURIT	Y NUMBER	ĝ s		elf) TO	O DATE OF BIRTH			Family	CO	
(Check One)	123 — 45 -	- 6789	0 Z	DE LIMOLLED IIV.			Mo.			Relation- ship	D
a. NEW enrollment	3. SPOUSE'S SOCIA	L SECURITY NUMBE	_		(MI)	(LAST)	1	Duy	''':	SELF	1
b. CHANGE of coverage		_	Α	Winnie	T. F	ooh	08	28	55	522 ,	
4A. \A/innio			+				 	 	 		-
vvinne	e T. Po	ooh									
Name 4563 F	isney Avenue	(Home Addr									
MUU1633	nsiley Avellue	(1 loine Addi.)	-				 	 			├ ──
City, State, ZIP Marys	ille, CA 95501										
4B. RESIDENCE ZIP C	ODE (If different from 4	A)									
5. Please check if	6. SEX	7. MARRIED									
Permanent Intermittent	Male	Yes								i	
Employee (applies to active State employees only)	Female	No									
8. PLAN CODE	9. NAME OF HEAL		-				Ш				
2381	PacifiCare of C					!					
10. GROSS PREMIUM	11. PRIMARY CARE PH	YSICIAN/MEDICAL GROUP									
\$ 205.48	Dr. Johnny R	ichleand	\vdash								
12. PRIOR PLAN CODE 13. PRIOR HEALTH PLAN											
				18. SUPPLEMENT	AL PLAN		DATE	OF B	BIRTH	Relation-	0
14 0	15 Downitting Front Date	GA SESSATIVE OAT	C C C C C C C C C C C C C C C C C C C	(FIRST)	(MI)	(LAST)	Mo.	Day	Yr.	ship	
14. Permitting Event Code	Mo. Day Year	16. EFFECTIVE DAT Mo. Day Year	4	1		i	1			ĺ	
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19. CHECK ONE											
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I elect to ENROLL IN salary or retirement	i (OK CHANGE 10) a n allowance to cover my sh										
_ `	above in Items 17 and/a				Public Employe	es' Medi	cal ar	nd Ho	ospita	i Care Ac	t.
	the Health Benefits Plan						1 44				
20. EMPLOYEE OR ANN		• •					21. M		TES Da	IGNED Y Ye	
► /S/Winnie T. Po	ooh	Daytime	e Pr	none (916) 55	5-5555		10		02	01 [']	idi
	O THE HEALTH B									22–27	■
22. DEDUCTION 23. Type (PLAN CODE action		24. PAY PERIOD Month Year	25.	PARTY CODE	26. EMPLO Design		27.	BAR	RGAII	IING UN	IT
2 3 8 (Check		10 01 01		1	R	MIUN			0	4	
28. AGENCY NAME (or Retir			29.	PAYROLL OFFICE CODE		CODE	31. UNIT CODE				
Department of		0	332		180						
32. I hereby certify under per		SIGNATURE OF HEAL	TU DI		33. Date recei		34. PHONE NUMBER				
, , ,					employing	office					
That I am a duly appointed, of the above named agency agency as provided by Sec	, and that payment by the	►/S/ Minnie			09 28	Yr. 01	(9	16)	33	3-282	28
Government Code is hereby tion of eligibility for the enre	approved. Final determina-	35. REMARKS Public	Ager	· · · · · · · · · · · · · · · · · · ·	lete boxes 2	2-24					
be made by the Board Employees' Retirement Syste	of Administration, Public	of		Forms							
Public Employees' Medical of the regulations implementing	and Hospital Care Act and										
the regulations implementing	the Act.										



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		<u> </u>	PLEASE	TY	'PE ◀							
1. TYPE OF ACTION	2. SOCIAL SECURIT	Ŷ	LIST ALL PERSO		ctuding self) TO	0	ATE	Family	0			
(Check One)	519 — 90 -	- 9000		0 7			Mo.	BIRTI Day		Relation- ship	D	
a. NEW enrollment b. CHANGE of coverage	3. SPOUSE'S SOCIA	L SECURI	TY NUMBER		(FIRST)	(MI)	(LAST)	1	1207	ļ ,,,,	SELF	+
c. CANCEL all coverage		4871			Mary	J.	Carling	04	10	50		
4A. Mary	J. Ca	arling			Frank	М.	Carling	05	04	60	husb.	
Mailing 10 Jun Address	_	Patricia .	J.	Carling	04	04	90	dtr.				
City, State, ZIP Los Ar	ngeles, CA 920	01					•					
4B. RESIDENCE ZIP C	ODE (If different from 4	A)										
5. Please check if Permanent Intermittent Employee (applies to active State employees only)		7. MARF	RIED Yes No									
8. PLAN CODE 2323	9. NAME OF HEALT Universal Care	TH PLAN		Γ								
10. GROSS PREMIUM	11. PRIMARY CARE PHY	SICIAN/MEI	DICAL GROUP									
\$ 438.39	Dr. Nathan Go	oodled	ge	-					-			
12. PRIOR PLAN CODE	13. PRIOR HEALTH	PLAN	<u> </u>	<u> </u>								
563 Kaiser					18. SUPPLEMEN				OF B		Relation-	0
14. Permitting Event Code 15. Permitting Event Date 16. EFFECTIVE DATE				0 0 E	(FIRST)	(MI)	(LAST)	Mo.	Day	Yr.	ship	<u> </u>
11. Formitzing Erone Godd	Mo. Day Year		Day Year					\dashv				
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I elect to ENROLL IN salary or retirement all dependents listed	enroll in a Health Benef I (OR CHANGE TO) a He allowance to cover my she above in Items 17 and/or the Health Benefits Plan	ealth Benef are of the c 18 are cli	its Plan as sho cost of enrolln gible family m	own : nent (in Items 8 and 9 ab as it is now or as it r ers as defined in the	ove and may be	authorize deduction the future. I als	ctions so cer cal an	rtify th	hat th spita	e names Care Ac	of
20. EMPLOYEE OR ANN	IUITANT'S SIGNATURE	(see prin	vacy informa	tion	on reverse)			21. Mo	DAT	_	GNED	
▶ /S/ Mary J. Car	ling		Day	ytin	ne Phone (6	10) 2	22-3333	09		Day 27	/ Ye: - ∣01	ar
PLEASE REFER T	O THE HEALTH B	ENEFITS	PROCED	URE	MANUAL FO	R CC	MPLETION				22–27	■
22. DEDUCTION PLAN CODE 2 3 2 Check One	2. Cancel	24. PAY Month 0 19	PERIOD Year 01	25.	PARTY CODE		EMPLOYEE DESIGNATION R					IT
28. AGENCY NAME (or Retir	/ s. <u>F</u> eege		1 - 1	29.	PAYROLL OFFICE CODE	E 30. A		31. UNIT CODE				
Department of		0		534	600							
32. I hereby certify under pen		SIGNATH	RE DE HEALT	H RF	NEFITS OFFICER	33 n		34 1	PHONE			
That I am a duly appointed,							nploying office Day Yr.					
of the above named agency agency as provided by Sec Government Code is hereby	, and that payment by the				Marks cies do not comp	09	28 01	(91	(b) v	32	3-000	<u> </u>
tion of eligibility for the enrobe made by the Board Employees' Retirement Syste Public Employees' Medical of the regulations implementing	of Administration. Public of Administration. Public on, in accordance with the land Hospital Care Act and		of				g plans due	to	mo	ve.		

Sample HBD-12 Changing Plans during Open Enrollment Using Workplace ZIP Code Election Form on file.



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(Check Or	•	546 — 12	. –	9891			OZ E	17. BASIC PLAN			Mo.	Day		Relation- ship	D
a. NEW 6	3. SPOUSE'S S	OCIAL	SECU	CURITY NUMBER	_	(FIRST)	(MI)	(LAST)	1		<u> </u>	SELF	Ť		
	L all coverage	321 _ 65		4563	}			Dannie	М.	Boone	04	14	58		
4A. Name	Dannie	M. Boone						Sarah A	٩.	Boone	01	11	59		
Mailing Address 9641 Betty Boope Dr. (Home Addr)															
City, State 7/P Las Vegas, NV 89021						,									
4B. RESIDE	NCE ZIP CO	DDE (If different fr	om 4A	900	21 (V	Vork									
5. Please		6. SEX Male		7. MAR	RRIED	···									
State employ		Female			No										
8. PLAN CO 2052)DE	9. NAME OF H Blue Shield				0									
10. GROSS F	REMIUM	11. PRIMARY CARE	PHYS	SICIAN/M	EDICAL G	GROUP				-					
\$ 433	.32	Margie Su	cces	ss, M	.D		\vdash								
12. PRIOR P	LAN CODE	13. PRIOR HEAL	.TH	PLAN											
2222 PERS Choice				Ĉ 6	18. SUPPLEMENT						Relation-	0 0			
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19. CHECK (NF .														
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20. EMPLOYE	E OR ANNI	JITANT'S SIGNAT	URE		-		Mo Day								
▶ /S/Dannie M. Boone Daytime P					ho	ne (916) 555	-55	55	09		05	01	aı		
PLEASE	REFER TO	THE HEALTH						MANUAL FO						22–27	_◀
22. DEDUCTION PLAN CODE 23. Type of action 2. Cancel 2 0 5 (Check One) 3. Change 1 2 2						25.	PARTY CODE 2	26.	EMPLOYEE DESIGNATION E	27. BARGAINING UNIT 99					
						29.	PAYROLL OFFICE CODE	30.	AGENCY CODE	31. UNIT CODE					
Department of Motor Vehicles						0		525	310						
32. I hereby cert	ify under pena	ity of perjury as foll	ows:	SIGNAT	URE OF	HEALT	i BE	NEFITS OFFICER		Date received in	34.	PHON	E NU	MBER	
of the above	named agency,	qualifed and acting offi	the 🌓	/S/	Per	son	ne	l Jones	м ₀. 09	employing office Day Yr. 10 01	(91	16)	333	3-282	28
Government C tion of eligibil be made by Employees' Ri Public Employ	ode is hereby a ity for the enrol the Board o tirement System	ons 22825–22832 of pproved. Final determi lment action specified of Administration, Pul n, in accordance with ad Hospital Care Act of the Act.	will blic the	5. REMA				cies do not comp Forms	lete t	ooxes 22-24					

Change of plan outside of Open Enrollment Using Residence/Work ZIP Code. Employer ZIP Code Election Form on file.



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PERS USE ONLY—DOCUMENT REFERENCE NUMBER

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1. TYPE OF ACTION 2. SOCIAL SECURITY NUMBER					ç c			cluding self) TO	0	DATE (BIRTH		Family	6
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c. CANCEL all cov		′ _— 65 _—	- 4321			Diane	R.	Waverly	05	06	58		
^{4A.} Dia	ne	R. W	averly			Dennis	Т.	Waverly	06	05	58	Husb.	<u> </u>
Name				(LAST)	-	-				-	_	71000.	-
Mailing 6754 Cross Road Lane													
City, State 71P Holl													
4B. RESIDENCE Z													
5. Please chec	10 00		7. MARRIED	<u> </u>	\top			· · · · · ·	-	\vdash			_
Permanent Interm	ittent	Male	Yes										
Employee (applies to State employees only)		Female	No										
8. PLAN CODE	9. NA	ME OF HEALT	TH PLAN		 				-	\vdash			
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10. GROSS PREMIU	IM 11. PI	RIMARY CARE PHY	'SICIAN/MEDICAL	GROUP									
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19. CHECK ONE		<u></u>									I		
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						in Items 8 and 9 ab							
						as it is now or as it : ers as defined in the							
		ith Benefits Plan	•	•				. ,			•		
20. EMPLOYEE OR	ANNUITANT	'S SIGNATURE	(see privacy	informa	ation	on reverse)			21.			GNED	
▶ /S/Diane R.	Waverly		Daytime	Pho	ne	(916) 555-12	212		12		Da 16	y Ye ⊹101	ar
PLEASE REFE	R TO THE	HEALTH B	ENEFITS PR	OCED	URE	MANUAL FO	R C	OMPLETION	OF	ITE	NS	22–27	4
	Type of 1	. New	24. PAY PER		25.	PARTY CODE	26.	EMPLOYEE	27.	BAF	RGAIN	ING UN	IT
PLAN CODE	Check \ 2		Month	Year		2	1	DESIGNATION			0	1	
0 5 6 (. Change	1 2	1				R	<u> </u>				
28. AGENCY NAME (or	Retirement Sy	stem)			29.	PAYROLL OFFICE COD	E 30.	AGENCY CODE	31.	UNIT			
CalPERS						0		275	530				
32. I hereby certify under	er penaity of p	erjury as follows:	SIGNATURE O	F HEALT	H BE	NEFITS OFFICER		Date received in employing office	34. PHONE NUMBER				
That I am a duly appo of the above named o	agency, and that	t payment by the	▶/S/Car	l Ed	its	, Jr.	M₀. 12	Day Yr. 116 01	(9	16)	38	9-123	34
agency as provided to Government Code is h	ereby approved.	. Final determina-	35. REMARKS P	ublic A	gen	cies do not com							
tion of eligibility for the be made by the B	oard of Admi	nistration, Public				Forms							
Employees' Retirement Public Employees' Me													
the regulations implem	enting the Act.	ı											