If you are waiving coverage, you must attach a signed "Opt-Out of City Medical Plan Coverage" form.

California Public Employees' Retirement System P.O. Box 942715 Sacramento, CA 94229-2715				Check here if you are NOT making any changes for 2017. Complete all highlighted sections, EXCEPT #17 (leave blank)									
HEALTH BENEFIT PLAN ENROLLMENT FORM PERS-HBD-12 (Rev. 6/13) CLAIMS TO THIS ADDRESS PLEASE TO				CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER									
(Check One)	TYPE OF ACTION (Check One) (2. SOCIAL SECURITY NUMBER) LEAVE BLANK		A C C T O I D O N E	LIST ALL PERSONS (including self) TO BE ENROLLED IN:				ATE O		Family Relation- ship	G E N D C E O R		
a. NEW enrollment b. CHANGE of coverage C. CANCEL all coverage LEAVE BLANK				(FIRST)	(MI)	(LAST)	Mo.	Day	Yr.	SELF	M F		
c. CANCEL all coverage LEAYE BLANK 4A.													
Name (FIRST)	(MI)	(LAST)		(FIRST)	(MI)	(LAST)							
Address City,	(Daytime Phone	Evening Phone											
State, ZIP				SSN	(8.4I)	(LACT)							
4B. RESIDENCE ZIP CODE (If different from 4A) 5. □ Please check if (6. GENDER) (7. MARRIED)			-	(FIRST)	(MI)	(LAST)							
Permanent Intermittent Employee (applies to active	nent Intermittent yee (applies to active employees only) Male Yes No			SSN									
State employees only) 8. PLAN CODE				(FIRST)	(MI)	(LAST)							
			_	SSN									
11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP \$													
12. PRIOR PLAN CODE 13. PRIOR HEALTH PLAN			A C C T O	18. SUPPLEMENTAL P (FIRST)	LAN (MI)			DATE OF BIRTH Mo. Day Yr.		Relation- ship		C O D E	
14. Reason Code	1 ° 1	16. EFFECTIVE DAT	, D				IVIO.	Day	111.				
Open Enrollment	Mo. Day Yr. 9/12/16	Mo. Day 20	17										
19. CHECK ONE ☐ I DO NOT elect to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act. ☐ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above 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 in items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act. ☐ I elect to CANCEL the Health Benefits Plan as shown in items 12 and 13 above.													
20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse				se of employee copy)				21. DATE SIGNED					
•	ELEPHON	IE NUMBER ()			M	0.	Day	Y	ear			
PLEASE REFER TO THE HEALTH BENEFITS PROCED 22. DEDUCTION PLAN CODE action Check One) 23. Type of action 2. □ Cancel Check One) 3. □ Change 11/16/2016				PARTY CODE 26. EMPLOYEE DESIGNATION				27. BARGAINING UNIT					
28. AGENCY NAME (or Retirement System) City of San Rafael 29. I				(ROLL OFFICE CODE 30. AGENCY CODE			E	31. UNIT CODE					
32. I hereby certify under penalty of perjury as follows: SIGNATURE OF HEA				LTH BENEFITS OFFICER 33. Date received in employing office									
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 determina-					Mo.	Day Ye	ear			85-306	3		
tion 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. 35. REMARKS of WHITE - HB PINK - Agency				Forms E - Employee	1	<u>, l</u>		1	~ <i>y</i> •				

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 will be used for administration of the Board's duties under the 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 another governmental agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that 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, Health Account Services requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits. Specifically, the California Public Employees' Retirement System 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 the Public Employees' Retirement System and other state agencies.
- 5. Coordination of benefits among carriers.

BINDING ARBITRATION

Enrollment in certain plans constitutes an agreement to have any issue of medical malpractice decided by neutral arbitration and waiver of any right to a jury or court trial. Refer to the health plan Evidence of Coverage booklet to determine if this provision is applicable to your plan.

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 CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number 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
- Billing of contracting agencies for employee/ employer contributions
- 4. Reports to CalPERS and other state agencies
- 5. Coordination of benefits among carriers
- 6. Resolving 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 to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).

