



California Public Employees' Retirement System
 Health Benefit Services Division
 P.O. Box 942714; Sacramento, CA 94229-2714
 (800) 237-3345

Declaration of Health Coverage
 HB-12A (01/01/98)

(INSTRUCTIONS ON REVERSE)

| EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER | NAME (FIRST) (MIDDLE) (LAST) |
|---|---|
| PART A <input type="checkbox"/> I elect to enroll myself and all eligible dependents. | |
| PART B-1 <input type="checkbox"/> I elect to enroll myself. My eligible dependents have other health insurance coverage. | If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment with 60 days from the date you lose coverage. |
| PART B-2 <input type="checkbox"/> I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage. | If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date. |
| PART C-1 <input type="checkbox"/> I decline enrollment for myself and my eligible dependents because we have other health insurance coverage. | If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date. |
| PART C-2 2. <input type="checkbox"/> I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage. | You can request enrollment for yourself and/or your dependents at any time. You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date. |

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependent, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependent, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

 Member's Signature
 HB-12A (01/98)

 Date Signed
 Original: Employee's Personnel File

 Health Benefits Officer's Signature
 Copy: Employee

INSTRUCTIONS - DECLARATION OF HEALTH COVERAGE (HB-12A)

| <i>Please contact your Health Benefits Officer if you have any questions regarding the HB-12A</i> | |
|---|--|
| Employee Information | Complete with the appropriate employee information. |
| PART A: | Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program. |
| PART B-1: | Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage. |
| PART B-2: | Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage. |
| PART C-1: | Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage. |
| PART C-2: | Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage. |

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

Special rules for retirement and death:

Consider these points as you decided whether to enroll, decline, or cancel enrollment for yourself or dependents.

- If you are not enrolled in a CalPERS-sponsored health plan on the date you separate employment, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are not enrolled on your CalPERS-sponsored health plan at that time, they will not be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.