

Office of Employer and Member Health Services PO Box 942714 Sacramento, CA 94229-2714 Toll Free: (888) CalPERS (225-7377) Fax: (916) 795-1313 Telecommunications Device for the Deaf: (916) 795-3240

Declaration of Health Coverage: HBD-12A		(INSTRUCTIONS ON REVERSE)		
EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME	(FIRST)	(MIDDLE) (LAST)	
PART A I elect to enroll myself and all eligible dependents.				
PART B-1 I elect to enroll myself. My eligible dependents have other health insurance coverage PART B-2 I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage. PART C-1 I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.		coverage, you can Benefits Program 60 days from the If you do not recyou or your depor until the next you can enroll in date of coverage	pendents lose health insurance n enroll in the CalPERS Health n. You must request enrollment within date you lose coverage. quest enrollment within 60 days, endents must wait at least 90 days Open Enrollment Period before n the Program. Your effective e will be the first of the month day waiting period or the Open etive date.	
PART C-2 I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.		dependents at any days after you re Open Enrollmenthe Program. Y be the first of the	enrollment for yourself and/or your y time. You must wait at least 90 equest enrollment or until the next at period before you can enroll in our effective date of coverage will e month following the 90 day r the Open Enrollment effective	
PART B: If you are currently enrolled in the a court orders health coverage for your dependent Benefits Officer or visit your personnel office for PART C: If you are not currently enrolled in as a result of marriage, birth, adoption, or placent dependents, you can enroll yourself and dependents.	its, you can rapplicab the Healt ment for a	an add your new de ole time limits. h Benefits Program doption, or if a cour	pendents. See your Health and you acquire new dependents rt orders health coverage for your	
office for applicable time limits. Special rules apply to retirement and death. I	Please rea	ad the back of this	form carefully.	
Member's Signature Date Si	gned		Health Benefits Officer's Signature	
Rev (3/09) Original:	Original: Employee's Personnel File		Copy: Employee	

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

Please contact your Health Benefits Officer if you have any questions regarding the HB-12A			
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: PART B-2:	 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. 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: PART C-2:	 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. 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 eligible to be enrolled in a CalPERS-sponsored health plan on the date you separate employement, 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 enrolled on your CalPERS-sponsored health plan at this time, they may be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.