Open Enrollment CalPERS Medical Health Benefits Application Instructions

This application must be completed in full for any New, Add, or Change to coverage.

SECTION A- Application Information

1. **Employee Name**: Enter the employees First, Middle, & Last name
2. **Hire Date**: Enter the date the employee started work (MM/DD/YYYY)
3. **CalPERS ID or Social Security Number**: Enter the employees whole SSN
4. **Date of Birth**: Enter the employees date of birth (MM/DD/YYYY)
5. **Gender**: Select Male or Female
6. **Residence Address:** Enter employees physical address
7. **Mailing Address:** Enter the mailing address if different than employees physical address
8. **Use Work ZIP Code for Health Eligibility:** Select yes if you would like to use 95380 instead of you residence ZIP Code as your health eligibility ZIP Code. If no, leave this box blank.
9. **Email Address**: Enter employees work or personal email address
10. **Primary Phone / Alternate:** Enter employees primary and secondary phone numbers

SECTION B- Type of Action

11. **Type of Action**: Select the action/change you wish to apply

SECTION C- Type of Permitting Event

12. **Type of Permitting Event:** Select the reason or qualifying event for the change of health benefits
13. **Permitting Event Date:** The date your action/change occurred (MM/DD/YYYY)
14. **Name of Health Plan:** Enter the medical plan you currently hold or wish to enroll/select
    - Health Plans: Anthem Blue Cross Select, Anthem Blue Cross Traditional, Blue Shield Access+, Kaiser, PERS Select, PERS Care, PERS Choice

SECTION D- Subscriber and Dependent Information

15. List yourself and all your dependents to be enrolled on your health plan (Self, Spouse, and children)
    - **Name:** Enter employees name and all dependent names
    - **Relationship Codes**: S-Spouse, DP-Domestic Partner, NC-Natural Child, SC- Step Child, AC- Adopted Child, DPC-Domestic Partner Child, PCR-Parent Child Relationship
    - **Gender** for each listed: Male or Female
    - **Date of Birth** for each listed: (MM/DD/YYYY)
    - **Social Security Number**: Enter full SSN for each listed
    - **Action:** Select Add or Delete for each dependent listed
    - **Primary Care Physician:** Enter the name of your doctor or dependent's doctor

SECTION E- Enrollment

16. **Accept:** Enter a check mark confirming you carefully read and reviewed the information in this section and you wish to continue with enrollment
17. **Decline:** Enter a check mark confirming you carefully read and reviewed the information in this section and you wish to decline enrollment
18. **Employee Signature & Date:** Enter employees signature giving authorization for enrollment & date (MM/DD/YYYY)