Human Resources Benefits Division, 4080 Lemon Street, P.O. Box 1569, Riverside, CA 92502, (951) 955-4981, benefits@rivco.org, fax: 951-955-3490

RIVCO 1HR putting people first

County of Riverside, Human Resources Department

2024 Active Benefit Election Form

Department Name:	**Bargaining Unit:**	**Employee ID:**	**Hire Date:**
Name:	**Home Phone:**	**Work Phone:**	**Cell Phone:**
Street Address:	**City:**	**State:**	**Zip:**
Email Address: ***(Required, if available)***	**Elected Coverage Begin Date** ***(must be first day of month)*****:**		
Date of Permitting Event:	**Permitting Event:**		

This form (4 pages) must be completed, signed, and returned to your Department Representative along with the attached CalPERS HBD-12 form (2 pages). You have 60 days from the date of the qualifying event to submit this paperwork. Failure to submit this paperwork timely, may result in denial of coverage/changes. Elections are effective the first day of the month following receipt of forms OR a later date if indicated above.

Medical Plan Options and Monthly Rates

Eligible employees may choose a medical plan based on where they live or work. Plan rates provided are **monthly** rates. **When electing a CalPERS Health Plan you can determine your Region and Health plan eligibility by utilizing the Search by Zip Code feature on CalPERS website: https://www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates/zip-search**

Decline	☐ No Coverage (W)	Declining Medical Coverage will result in your forfeiture of Flexible Benefit Credits. You must also submit a ***Decline Coverage Acknowledgment Form.***
Medical Waiver*	☐ Medical Waiver Program (999)	*Medical Wavier: See current Benefits Annual Enrollment Guide. If you are eligible, you may select Medical Waiver Program and receive a Taxable Cash Payment. The amount received is based on your most recent hire date. You must also provide proof of other eligible group medical coverage and submit a **Decline Coverage Acknowledgement Form**.

Medical Waiver/Proof of Other Medical Insurance

Complete this section if you have elected Medical Waiver through the County of Riverside.

Name of Policy Holder	Policy Holder Social Security Number	Name of Insurer	Policy Group Number	Policy Holder Date of Birth

CalPERS Medical Plan Options and Monthly Rates

Use Work ZIP Code for Health Eligibility: ☐ YES ☐ NO

	Region 2 (Orange, San Diego, and Imperial Counties)	**Region 3** (Riverside, Los Angeles, San Bernardino, and Ventura Counties)	**Out of State Region** (Residents Outside of California)
Anthem Select HMO	☐ Single $807.72 (5071) ☐ Two-Party $1615.42 (5072) ☐ Family $2100.06 (5073)	☐ Single $841.14 (5081) ☐ Two-Party $1682.26 (5082) ☐ Family $2186.94 (5083)	Not Available
Anthem Traditional HMO	☐ Single $1034.38 (5101) ☐ Two-Party $2068.76 (5102) ☐ Family $2689.40 (5103)	☐ Single $1012.68 (5111) ☐ Two-Party $2025.34 (5112) ☐ Family $2632.94 (5113)	Not Available
Blue Shield Access + HMO	☐ Single $869.14 (5261) ☐ Two-Party $1738.28 (5262) ☐ Family $2259.76 (5263)	☐ Single $756.66 (5271) ☐ Two-Party $1513.30 (5272) ☐ Family $1967.30 (5273)	Not Available
Blue Shield Trio HMO	☐ Single $810.24 (0881) ☐ Two-Party $1620.48 (0882) ☐ Family $2106.62 (0883)	☐ Single $704.70 (4521) ☐ Two-Party $1409.38 (4522) ☐ Family $1832.20 (4523)	Not Available
Health Net Salud y Mas HMO	☐ Single $684.78 (5311) ☐ Two-Party $1369.54 (5312) ☐ Family $1780.40 (5313)	☐ Single $630.14 (5321) ☐ Two-Party $1260.26 (5322) ☐ Family $1638.34 (5323)	Not Available

Department Name:	Bargaining Unit:	Elected Coverage Begin Date:
Name:	Employee ID:	Date of Permitting Event:

CalPERS Medical Plan Options and Monthly Rates

Use Work ZIP Code for Health Eligibility: ☐ YES ☐ NO

	Region 2 (Orange, San Diego, and Imperial Counties)	Region 3 (Riverside, Los Angeles, San Bernardino, and Ventura Counties)	Out of State Region (Residents Outside of California)
Kaiser Permanente HMO	☐ Single $904.96 (5341) ☐ Two-Party $1809.90 (5342) ☐ Family $2352.88 (5343)	☐ Single $865.42 (5351) ☐ Two-Party $1730.82 (5352) ☐ Family $2250.08 (5353)	☐ Single $1312.46 ☐ Two-Party $2624.90 ☐ Family $3412.38
PERS Gold PPO	☐ Single $799.44 (6141) ☐ Two-Party $1598.88 (6142) ☐ Family $2078.54 (6143)	☐ Single $785.28 (6151) ☐ Two-Party $1570.56 (6152) ☐ Family $2041.74 (6153)	Not Available
PERS Platinum PPO	☐ Single $1151.50 (6021) ☐ Two-Party $2303.00 (6022) ☐ Family $2993.90 (6023)	☐ Single $1131.48 (6031) ☐ Two-Party $2262.94 (6032) ☐ Family $2941.82 (6033)	☐ Single $1146.86 (6041) ☐ Two-Party $2293.72 (6042) ☐ Family $2981.84 (6043)
PORAC PPO	☐ Single $926.00 (5931) ☐ Two-Party $1863.00 (5932) ☐ Family $2371.00 (5933)	☐ Single $926.00 (5941) ☐ Two-Party $1863.00 (5942) ☐ Family $2371.00 (5943)	☐ Single $1056.00 (1501) ☐ Two-Party $2144.00 (1502) ☐ Family $2540.00 (1503)
Sharp HMO	☐ Single $833.24 (5751) ☐ Two-Party $1666.48 (5752) ☐ Family $2166.42 (5753)	Not Available	Not Available
United Healthcare Alliance HMO	☐ Single $837.88 (5771) ☐ Two-Party $1675.76 (5772) ☐ Family $2178.50 (5773)	☐ Single $826.44 (5781) ☐ Two-Party $1652.88 (5782) ☐ Family $2148.74 (5783)	Not Available
United Healthcare Harmony HMO	☐ Single $792.66 (3991) ☐ Two-Party $1585.30 (3992) ☐ Family $2060.90 (3993)	☐ Single $734.76 (4751) ☐ Two-Party $1469.52 (4752) ☐ Family $1910.38 (4753)	Not Available

Flexible Spending Account (FSA)

You must re-enroll each year. Complete the election information below. If no election is entered below, your annual election will be $0.

Flexible Spending Account	Current Annual Election	New Annual Election
Health Care Account: Elect an annual amount between $240 and $3,200	$	$
Dependent Care Account (i.e., Child Care): Elect an annual amount between $240 and $5,000	$	$

Dental Plan Options and Monthly Rates

DeltaCare USA DHMO: High Option (10A)	☐ Single	$21.62	(DH1)
	☐ Two-Party	$32.98	(DH2)
	☐ Family	$51.86	(DH3)
Delta Dental PPO	☐ Single	$45.00	(DP1)
	☐ Two-Party	$78.00	(DP2)
	☐ Family	$115.00	(DP3)
Local Advantage Plus	☐ Single	$32.26	(151)
	☐ Two-Party	$61.50	(152)
	☐ Family	$91.50	(153)
Local Advantage Blythe	☐ Single	$20.98	(361)
	☐ Two-Party	$32.02	(362)
	☐ Family	$50.36	(363)
Decline (W)	☐ Waive	$0	

Department Name:	Bargaining Unit:	Elected Coverage Begin Date:
Name:	Employee ID:	Date of Permitting Event:

Vision Plan Options and Monthly Rates

EyeMed Vision Care (EyeMed) Plan 1 (Eye Exam and Eyewear) ***SEIU, LIUNA and RSA Public Safety Unit Only***	☐ Single	$8.56	(M11)
	☐ Two-Party	$12.92	(M12)
	☐ Family	$17.48	(M13)
EyeMed Vision Care (EyeMed) Plan 2 (Eyewear Only) ***SEIU, LIUNA and RSA Public Safety Unit Only***	☐ Single	$7.22	(M21)
	☐ Two-Party	$11.50	(M22)
	☐ Family	$15.88	(M23)
Vision Service Plan (VSP) ***Resident Classifications, DDAA, LEMU and Employees Represented by the Management Resolution.***	Employer Paid Benefit		
Waive (W)	☐ Waive	$0	

Employee/Dependent Information

Enter below information for yourself and any eligible dependents you are enrolling into your medical, dental, and/or vision plans.

A provider selection is required for all HMO plans (excluding Kaiser). Provider ID numbers are listed on the carrier's website or can be obtained by calling the health or dental plan. ***If you do not select a provider, one will automatically be selected for you by the carrier.*

EMPLOYEE

Relationship	Employee Name:	Date of Birth:	☐ Male ☐ Female	Social Security #
SELF				

Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

DEPENDENT #1

Relationship:	Dependent Name:	Date of Birth:	☐ Male ☐ Female	Social Security #

Tax Qualified Dep?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

Marriage or Domestic Partnership Date (mm/dd/yyyy):

DEPENDENT #2

Relationship:	Dependent Name:	Date of Birth:	☐ Male ☐ Female	Social Security #

Tax Qualified Dep?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

DEPENDENT #3

Relationship:	Dependent Name:	Date of Birth:	☐ Male ☐ Female	Social Security #

Tax Qualified Dep?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

DEPENDENT #4

Relationship:	Dependent Name:	Date of Birth:	☐ Male ☐ Female	Social Security #

Tax Qualified Dep?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

Department Name:	Bargaining Unit:	Elected Coverage Begin Date:
Name:	Employee ID:	Date of Permitting Event:

Release of Information: I authorize any physician, health care practitioner, hospital or other health care facility, clinic, health care service plan, or any other person or entity to release to any health care plan provider of the County of Riverside, a health care service plan, a self-insurer, or any insurance company, or its designee, all medical or personal information related to myself or any covered dependent, including mental health medical records from drug and alcohol abuse treatment or prevention, for the following purposes: Diagnosis or treatment; Payment of health services rendered; Billing, claims management, medical data processing, or other administrative function of the health plan in which I am enrolled through the County; Peer review, including reviewing the competence or qualifications of health care professionals; Utilization review and quality assurance, including reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges; Handling of member grievances or appeals, external independent review, or other health dispute resolution; Coordination of care with providers of health care or other health care service plans; Administering the health benefit plan; Chronic disease management programs, to monitor or administer care of a covered benefit; to verify my participation in other healthcare coverage if I elected to waive County sponsored benefit and other uses specifically authorized by law. This authorization is effective immediately and remains in effect for the duration of coverage under my health plan provider through the County of Riverside.

Binding Arbitration: I understand that the health plans that the County of Riverside offers use neutral binding arbitration to resolve disputes between Members, including but not limited to, claims of malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and the health plan. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceeding. The health plan and myself (and/or any enrolled family member), the parties to this agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. For additional information about each plan's arbitration provision, I may refer to the Disclosure and Evidence of Coverage, copies of which are available from each health plan.

Changes in Coverage: If you or your dependents experience a qualifying event resulting in a change in family status, you must contact Human Resources to request an enrollment change within 60 days from the date of the qualifying event. If you do not request enrollment within 60 days, you must wait until the next County Annual Enrollment period before you will be permitted to make a change.

Medical Waiver: I understand that if I waive medical coverage offered through the County of Riverside that I am subject to an annual audit whereby; I will have to provide proof of my other group (not individual) medical coverage when requested by the County. If at any time I do not have other group medical coverage, I understand I am not eligible for any Flexible contributions for any month that I do not have other group medical coverage and will have to repay the County for Flexible contributions that I was not eligible to receive.

Health Insurance Portability and Accountability – Special Enrollment Rights: If you are waiving enrollment for yourself and your dependents (including your spouse/domestic partner) because of other health insurance coverage, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be eligible to enroll yourself and your dependents, provided that you request enrollment within 60 days after the qualifying event occurs.

A Notice of Privacy Practices will be included in the Evidence of Coverage booklets and is available on the carrier websites or by calling Customer Service.

Employee's Authorization, Release and Signature:

I understand that I must meet the eligibility requirements of my elections as indicated on this Benefit Enrollment form. Submission of this Benefit Election Form is not confirmation that eligibility requirements have been met or verified.

I have read, understand and agree to the terms and conditions set forth in this Benefit Election Form, including the Release of Information, Binding Arbitration, Changes in Coverage and Medical Waiver, if applicable.

I certify that the information on this form is complete and correct and understand that, if it is not, I may be subject to disciplinary action by the County of Riverside. I understand that I must meet the eligibility requirements of each benefit plan that I have elected. I understand that submission of this enrollment form is not a confirmation that eligibility requirement has been met or verified. I also certify that the names of all dependents listed above for medical, dental, and vision coverage are my eligible dependents under the County of Riverside's Flexible Benefit Program. If I have enrolled a domestic partner and/or any dependent of a domestic partner that are not tax dependents as defined by the Internal Revenue Code Section 125, I understand that the Internal Revenue Service regulations require that the fair market value of domestic partner coverage will be included in my taxable income for FICA, Medicare, and Federal withholding purposes, and that the County of Riverside is obligated to withhold and report taxes on the fair market value of the domestic partner coverage.

Premium Collection - I authorize the County of Riverside to deduct from my County of Riverside pay warrant, all premiums required for the coverage elections I have selected on this enrollment form. I understand that the County of Riverside collects premiums for the medical, dental and vision plans a month in advance of the coverage effective date and the coverage begin date I select may require the collection of retroactive premiums. I further authorize the County of Riverside to deduct all premiums due up to and including my full pay warrant and from my final pay warrant at termination.

I certify that I have read, understand, and agree to the terms outlined on this Benefit Election Form.

Signature _____ Date _____

Health Benefits Plan Enrollment for Active Employees (HBD-12)

Return to:
County of Riverside - Employee Benefits Division
Mail: P.O. BOX 1569 Riverside, CA 92502
Email: benefits@rivco.org
Fax: 1-951-955-3490

SECTION A: Applicant Information

Employee ID #

1. **Employee Name:** *(First)* *(M.I.)* *(Last)*
2. **Hire Date:** (mm/dd/yyyy)
3. **CalPERS ID or Social Security Number:**
4. **Date of Birth:** *(mm/dd/yyyy)*
5. **Gender:** ☐ Male ☐ Female ☐ Nonbinary
6. **Physical Address:** *(Street)* *(City)* *(State)* *(ZIP)* *(County)*
7. **Mailing Address** (If different): *(Street)* *(City)* *(State)* *(ZIP)* *(County)*
8. **Use Work ZIP Code for Health Eligibility**: ☐ Yes ☐ No *If yes, enter zip code here: (ZIP)*
9. **E-mail Address:**
10. **Primary Phone:** **Alternate:**

SECTION B: Type of Action

11. ☐ Enroll in a Health Plan ☐ Add/Delete Dependents ☐ Change Health Plan ☐ Cancel All Coverage ☐ Decline Coverage

SECTION C: Type of Permitting Event

12. ☐ New Employee ☐ New Contracting Agency ☐ Marriage or Domestic Partnership Date *(mm/dd/yyyy)*: ☐ Open Enrollment ☐ Move
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/ Adoption ☐ Other:
13. **Permitting Event Date**: (mm/dd/yyyy)
14. **Name of Health Plan**: (If changing health plans, list new plan name)

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents)

15.

Name (First, M.I., Last)	Relationship Code *1	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF	☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	

*1 **Relationship Codes:** **S** - Spouse **DP** - Domestic Partner **NC** - Natural Child **SC** - Step Child **AC** - Adopted Child **DPC** - Domestic Partner Child **PCR** - Parent Child Relationship

SECTION E: Enrollment

16. **To enroll, carefully review the information in this section and check the box:**

☐ **I ELECT TO ENROLL** in (or **MAKE CHANGES TO**) a health benefits plan as indicated above and agree to authorize deductions from (1) my salary to cover my share of the cost of enrollment as it is now or as it may be in the future (2) my retirement allowance to continue health benefits coverage into retirement. **I CERTIFY** that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. **I AGREE** to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

17. **To decline, carefully review the information in this section and check the box:**

☐ **I DECLINE ENROLLMENT** into the CalPERS Health Program for myself and my dependents.

I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the 90 day waiting period or the OE effective date.

18. **Employee Signature:**
19. **Date:** *(mm/dd/yyyy)*

SECTION F: CalPERS 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 the system being unable to perform its functions regarding your status.

Please do not include information that is not requested.

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

SECTION G: 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 is used for administration of the CalPERS Board's duties under the Public Employees' 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 other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the 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, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The CalPERS health program 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 CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

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

SECTION H: For Employer Use

Please retain original signed form and all supporting documentation or affidavits in employee file. DO NOT send to CalPERS.

20. **Agency Name:**	21. **Date of Hire**: *(mm/dd/yyyy)*	22. **Retirement System**: ☐ CalPERS ☐ CalSTRS ☐ Other
23. **CalPERS Employer ID:**	24. **Division ID:**	25. **Employee Bargaining Unit/Employee Group:**
26. **Payroll Office:** ☐ State Controller's Office ☐ Non Central ☐ Public Agency Billing	27. **Date Received by Employer:**	28 **Effective Date:** *(mm/dd/yyyy)*

I hereby certify under the penalty of perjury that I am a duly appointed, qualified and acting Health Benefits Officer (HBO) of the above named agency, and the payment by the agency as provided by Section 22870-22905 of the Government Code is hereby approved. Final determination 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 and the regulations implementing the Act.

29. **Health Benefits Officer:** (Print name)	30. **Signature:**	31. **Date:** *(mm/dd/yyyy)*	32. **Phone Number:**

33. **Remarks:**

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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
3. 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).