Berkeley Unified School District

HEALTH BENEFIT ENROLLMENT FORM (PERS-HBD-12)

EMPLOYEE INFORMATION

1. Type of Action: ☐ a. NEW Enrollment ☐ b. CHANGE of coverage ☐ c. CANCEL all coverage	2. SOCIAL SECURITY NUMBER	LIST ALL PERSONS (Including self) TO BE ENROLLED IN:	Date of Birth (Mo. Day Yr.)	Family Relation-ship	Gender M/F
	3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SEC. NO.	(First) (MI) (Last)		SELF	
		SSN:			
		(First) (MI) (Last)		Spouse	
		SSN:			
4A. Name:		(First) (MI) (Last)		Son Daughter	
Physical Address:		SSN:			
City, State ZIP Code		(First) (MI) (Last)		Son Daughter	
		SSN:			
Mailing Address: City, State ZIP Code:		GENDER: ☐M ☐F	Married: ☐ Yes ☐ No	For Disabled Dependent Health Benefit: Please attach Member Questionnaire for Dependent.	
Daytime Phone:	Evening Phone:	Hire Date:	Date of marriage:		

NAME OF HEALTH PLAN:		PRIOR HEALTH PLAN:	
PRIMARY CARE PHYSICIAN/ HEALTH GROUP:		PRIOR PLAN CODE:	
PERMITTING EVENT DATE:		REASON CODE:	
EFFECTIVE DATE:			

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 above.

EMPLOYEE OR ANNUITANT'S SIGNATURE (SEE PRIVACY INFORMATION ON REVERSE OF EMPLOYEE COPY)

➢	Date signed:
➢ Telephone Number:	

➢ **PLEASE REFER TO HEALTH BENEFITS PROCDURE MANUAL FOR COMPLETION OF FOLLOWING ITEMS.**

BARGAINING UNIT		Signature of Health Benefits Officer	
DATE RECEIVED		Name and Title	
PHONE NUMBER		Date	