HUMAN RESOURCES MANAGEMENT DEPARTMENT

2022 Cafeteria Plan Option

For New Enrollees into the Cafeteria Plan, Complete and Return the Following:

1) Completed Cafeteria Plan Enrollment Form
2) Completed Health Benefits Plan Enrollment (HBD-12) form, with the following sections completed:
   - Section A: Applicant Information
   - Section E, #18 – Sign and Date
3) Attach proof of medical coverage

For Current Enrollees who elect to cancel the Cafeteria Plan payments and enroll into a City offered medical plan, Complete and Return the Following:

1) Completed Cancellation of Cafeteria Plan Option Form
2) Complete the Health Benefits Plan Enrollment (HBD-12) Form, with the following sections completed:
   - Section A: Applicant Information
   - Section C, number #14 and #15
   - Section E: Sign and Date

Current Enrollees Continuing into 2022

You will receive a separate email from Jessica Somera regarding how to continue your Cafeteria Plan payments into 2022.

HUMAN RESOURCES MANAGEMENT DEPARTMENT

CAFETERIA PLAN ENROLLMENT FORM

TO: Jessica Somera, Senior Personnel Analyst

FROM: _____
(Employee Name)

SUBJECT: *NEW CASH IN LIEU OF CALPERS MEDICAL PLAN PARTICIPANT*

DATE: _____
(Print Date)

I, _____, am electing to enroll in the City's cash in Lieu of CalPERS medical coverage during the City's Open Enrollment period, which will take effect **January 1, 2022**. The attached documentation verifies I have medical coverage with another health plan.

Attach a copy of your current medical card to this Memo along with a completed and signed CalPERS Health Benefit Plan form (HBD-12).

_____ _____
Employee Signature Date

If you or your dependent loses health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose 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.

Attachments: Form HBD12 (completed and signed)
Proof of medical coverage

(Rev 8/2020)

Health Account Management Division
P.O. BOX 942715
Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545
www.calpers.ca.gov

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

SECTION A: Applicant Information

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:** City of Richmond	**21.** **Date of Hire:** *(mm/dd/yyyy)*	**22.** **Retirement System:** ☒ CalPERS ☐ CalSTRS ☐ Other
23. **CalPERS Employer ID:** 2751275565	**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)* 01/01/2022

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:**

HUMAN RESOURCES MANAGEMENT DEPARTMENT

For Current Enrollees who elect to cancel the Cafeteria Plan payments and enroll into a City offered medical plan, please continue on to pages six (6) through eight (8).

HUMAN RESOURCES MANAGEMENT DEPARTMENT

CANCELLATION OF CAFETERIA PLAN OPTION VIA OPEN ENROLLMENT

TO: Jessica Somera, Senior Personnel Analyst

FROM: _____
(Employee Name)

SUBJECT: REQUEST TO CANCEL CAFETERIA PLAN OPTION

DATE: _____

During the CalPERS Open Enrollment period, I am requesting to cancel my Cafeteria Plan Option effective, December 31, 2021. I elect to enroll myself in one of the City of Richmond's CalPERS medical plans effective, **January 1, 2022**.

Please cease paying me the $_____ monthly Cafeteria Plan benefit effective, **December 31, 2021**.

_____ _____
Employee Signature Date

Cc: Payroll Division
Personnel File

(Rev 8/2020)

Health Account Management Division
P.O. BOX 942715
Sacramento, CA 94229-2715
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Health Benefits Plan Enrollment for Active Employees (HBD-12)

SECTION A: Applicant Information

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	
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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:**

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33. **Remarks:**