CalPERS

GROUP CONTINUATION COVERAGE
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT
(COBRA) PERS-HBD-85 (Rev 05/19)

Health Account Management Division
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INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE REVERSE SIDE. *PLEASE TYPE*

PART A: TYPE OF ACTION AND DATES

1.Type of Action

☐ NEW

☐ CHANGE

☐ CANCEL

2. TYPE OF PERMITTING EVENT

☐ EMPLOYMENT SEPARATION/TIME BASE REDUCTION
☐ DIVORCE/LEGAL SEPARATION
☐ CHILD CEASES TO BE A DEPENDENT
☐ DEATH OF AN EMPLOYEE/RETIREE
☐ DEPENDENT ELIGIBILITY VERIFICATION
☐ DEPENDENT CONTINUATION-ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE
☐ SSA CERTIFIED DISABILITY - 11 MONTH EXTENSION

3. EVENT DATE

4. COBRA ENROLLMENT PERIOD

FROM 01

TO

PART B: ENROLLEE INFORMATION

5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER)

CalPERS ID or
SOCIAL SECURITY NUMBER

NAME

ADDRESS

CITY, STATE, ZIP

PRIMARY PHONE NUMBER

MARRIED ☐ YES ☐ NO

DATE OF BIRTH

GENDER
☐MALE ☐FEMALE ☐NON-BINARY

PART C: CARRIER INFORMATION

7. NAME AND ADDRESS OF HEALTH PLAN
(SUBMIT PAYMENT DIRECTLY TO THE CARRIER)

PLAN CODE: _____

PREMIUM: $ _____

PHONE:

6. CalPERS SUBSCRIBER/MEMBER (EMPLOYEE)

CalPERS ID or
SOCIAL SECURITY NUMBER

SUBSCRIBER NAME

MEDICAL GROUP OR CBU

PART D: DEPENDENT INFORMATION

ACTION CODE	8. LIST OF ALL PERSONS (including self) TO BE ENROLLED:			
	FIRST	MI	LAST	CalPERS ID or SSN
	DATE OF BIRTH	FAMILY RELATIONSHIP		
		Self		
	FIRST	MI	LAST	CalPERS ID or SSN
	DATE OF BIRTH	FAMILY RELATIONSHIP		
	FIRST	MI	LAST	CalPERS ID or SSN
	DATE OF BIRTH	FAMILY RELATIONSHIP		
	FIRST	MI	LAST	CalPERS ID or SSN
	DATE OF BIRTH	FAMILY RELATIONSHIP		

PART E: ENROLLMENT CHANGES

9. NAME OF PRIOR HEALTH PLAN	11. TYPE OF PERMITTING EVENT	12. PERMITTING EVENT DATE	13. EFFECTIVE DATE OF CHANGE
10. PRIOR PLAN CODE			01

PART F: SIGNATURE OF ENROLLEE

14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED IN PART C. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.

SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION)

DATE SIGNED

PART G: AGENCY INFORMATION

15. AGENCY NAME _____

AGENCY CODE _____ UNIT CODE _____

16. HEALTH BENEFITS OFFICER'S SIGNATURE

DATE RECEIVED _____ PHONE _____

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information is collected pursuant to the Government Code Sections (20000 et. seq) and will be used for administration of the Board's duties under the California 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 another government agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Security and Privacy Officer, CalPERS, 400 Q Street, Sacramento, CA 95811.

INSTRUCTIONS FOR THE COMPLETION OF THE FORM HBD-85 (05/2019)

Part A

1. Type of Action
   a. Check " NEW " if this your new/initial enrollment
      i. (***Note:*** There cannot be a break in coverage between the end of CalPERS active health coverage and the beginning of COBRA enrollment)
   b. Check " CHANGE " if you are adding or deleting dependents, or for a plan change
   c. Check "Cancel" if you are canceling your COBRA enrollment
      i. You can skip the rest of the sections in Part A
      ii. Complete Part B (5 & 6), Part E (13)
2. Check applicable Type of Permitting Event
3. Provide original Event Date (permanent separation, divorce date, etc.)
4. Enter original COBRA Enrollment Period

   Examples:

   Permanent Separation date 4/15/19 (COBRA Enrollment Period: From 6/1/2019 to 11/30/2020)
   Child attains age 26 on 6/15/19 (COBRA Enrollment Period: From 7/1/19 to 01/01/2021)

Part B

5. Provide all requested information
6. Identify the employee if the COBRA enrollee is a former dependent

Part C

7. Identify the carrier. New COBRA enrollees may choose any carrier within their residential or work ZIP code area. Carrier changes are also allowed during the Open Enrollment period or due to a move. The health plan carrier's name, address, and phone number can be found in the annual Health Benefit Summary available in all employing agencies. *COBRA premium payments is the responsibility of the COBRA enrollee and must be made directly to the carrier.*

Part D

8. List all dependents to be enrolled, including self (if applicable)

Action Code:

i. Use "A" to indicate which dependent is being added (or newly enrolled)
ii. Use "D" to indicate if a dependent is being deleted from an existing COBRA enrollment
iii. An Action Code is not required when changing carriers

Important Note: The addition and deletion of dependents is regulated by time limits which are identical to those for active employees.

Part E

9. Name of Prior Health Plan (if changing carriers)
10-13. To be completed by the current or former agency's Health Benefits Officer

Part F

14. Signature of COBRA enrollee and date signed

Part G

15-16. To be completed by the current or former employing agency's Health Benefits Officer. CalPERS is the "employing agency" for former dependents of retirees.

IMPORTANT: It is the responsibility of the COBRA enrollee to report enrollment changes in a timely manner. Enrollment change requests must be submitted in accordance with existing regulations, laws, and the time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Part G.

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 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).