Health Benefits Plan Enrollment

Insurance and Benefits Trust (IBT) Health Plan
2960 Advantage Way
Sacramento, CA 95834
Telephone number 800-655-6397 Fax 916-999-8892
www.ibtofporac.org

SECTION A: Applicant Information

1. **Employee Name:** *(First)* *(M.I.)* *(Last)*
2. **Hire Date:** (yyyy/mm/dd)
3. **Social Security Number:**
4. **Date of Birth:** *(yyyy/mm/dd)*
5. **Gender:** ☐ Male ☐ Female
6. **Residence 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 *(yyyy/mm/dd)*: ☐ Open Enrollment ☐ Move
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/ Adoption ☐ Other:
13. **Permitting Event Date**: (yyyy/mm/dd)
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 to be enrolled on your health plan)

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

*1 **Relationship Codes:** **W** - Wife H-Husband D-Daughter S-Son **P** - Domestic Partner **X** - Step Child **F** - Foster **A** - Adopted Child O - Other

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 my salary to cover my share of the cost of enrollment as it is now or as it may be in the future. **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** 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 IBT 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:** *(yyyy/mm/dd)*

SECTION F: Insurance and Benefit Trust (IBT) Privacy Notice

The privacy of personal information is of the utmost importance to the IBT. 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. 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 IBT Privacy Officer at 2960 Advantage Way, Sacramento, CA 95834 or call our Customer Contact Center at (800-655-6397).

SECTION G: Privacy Information

Submission of the requested information is mandatory. Failure to supply the information may result in IBT being unable to perform its functions regarding your status.

You have the right to review your IBT membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the IBT Customer Contact Center at 1-800-655-6397.

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 IBT health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The IBT 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. Coordination of benefits among health plans.
5. 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.

20. **Agency Name:**	21. **Date of Hire**: *(yyyy/mm/dd)*	22. **Retirement System**: ☐ CalPERS ☐ CalSTRS ☒ Other
23. **PORAC membership number:**	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:** *(yyyy/mm/dd)*

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 IBT.

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

33. **Remarks:**

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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 IBTs' first request for disclosure of your Social Security number, then disclosure is mandatory. 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:

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2. Payroll deduction/state contributions
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