Insurance and Benefits Trust

of PORAC

Individual RAM Application for IBT Participation

Last Name: _____ First Name: _____ Middle Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
E-Mail Address: _____
Date of Birth: _____ Social Security No.: _____
PORAC Member ID NO.: _____
Agency/Association at Time of Separation: _____
Job Title at Time of Separation: _____
Retirement/Separation Date: _____
Type of retirement (service, disability, etc.): _____

Are you currently enrolled in the PORAC Anthem Blue Cross PPO Health Plan? Yes _____ No _____
If Yes, provide Anthem Blue Cross ID No.: _____
Are any dependents covered under your current health plan? Yes _____ No _____
If Yes, please provide names, dates of birth and relationship to you:

_____

Please check any insurance products you are interested in or are already enrolled in:
PLEASE NOTE: You must be a sworn officer (safety personnel to enroll in the PORAC Anthem Blue Cross Health Plan)

To enroll in the CalPERS Health Plan, your employer must be a contracting agency under PEMCHA

CalPERS Health	_____ Enrolled _____ Interested	AFLAC	_____ Enrolled _____ Interested	Term Life	_____ Enrolled _____ Interested
Delta Dental	_____ Enrolled _____ Interested	VSP Vision	_____ Enrolled _____ Interested	Cal Casualty Home/Auto	_____ Enrolled _____ Interested

Please state your reason for seeking approval from IBT: _____

APPLICATION WILL NOT BE ACCEPTED UNLESS A COPY OF YOUR RETIREMENT IDENTIFICATION CARD IS PROVIDED. YOU MUST PROVIDE A COPY OF THE FRONT AD BACK SIDE OF YOUR RETIREMENT IDENTIFICATION CARD.

The undersigned acknowledges that any benefits approved are done so with the understanding that he/she must remain a RAM member in in good standing with PORAC and that the Association he/she retired from must also remain a member in good standing with PORAC. If the Association he/she retired from withdraws from PORAC, he/she understands that all benefits provided through the Insurance and Benefits Trust of PORAC will be terminated.

The undersigned further acknowledges that he/she has read and understands the Trust's Benefit Participation Policy and this form and that the information provided in this application is true and correct and that the Trust will rely on the information provided to approve or deny access to any and all benefits being requested by member.

Applicant's Signature: _____ Date: _____

The information requested in this process will be confidential and is used solely for verification of your identification.
Your approval and confirmation may take up to 30 business days.

PORAC Use: PORAC RAM ID: _____ Member Effective Date: _____
Prior PORAC Association ID: _____ Processed by: _____

Please return your completed and signed form to:

IBT of PORAC • 2960 Advantage Way • Sacramento, CA • 95834