



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, Anthem Blue Cross ID Number: _____
 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 _____	AFLAC _____	Enrolled _____	Term Life _____	Enrolled _____
_____	Interested _____	_____	Interested _____	_____	Interested _____
Delta Dental _____	Enrolled _____	VSP Vision _____	Enrolled _____	Cal Casualty _____	Enrolled _____
_____	Interested _____	_____	Interested _____	Home/Auto _____	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 AND 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 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 understand 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:
 PORAC • 4010 Truxel Road • Sacramento, CA • 95834