Director - Region 1 - 2023

Effective January 1, 2023

Benefits Election

☐ **I wish to receive my 1095-C form electronically** **NAME** _____

☐ **I wish to receive my 1095-C form by mail**

Use the Dropdown Menu to Identify the Coverage You are Selecting

*****Deductions are Bi-Monthly*****

Benefit	Plan	Selection	Bi-Monthly Total
Dental	Premier Access	No Coverage - $0.00	
Vision	VSP	No Coverage - $0.00	
Medical Employees residing in other zip codes may have additional plan choices.	*PERS Platinum*	No Coverage - $0.00	
	HMO Select	No Coverage - $0.00	
	HMO Blue Shield Trio	No Coverage - $0.00	
	PERS Gold	No Coverage - $0.00	
	PORAC *(Police Only)*	No Coverage - $0.00	
	Enter Alt Plan Name:	**Enter Level of Coverage Selected:**	**Enter Premium Amount:**
Bi-Monthly Total Premium Cost Before Cafeteria Plan Amount is Applied			$ 0.00

CalPERS Medical Enrollment: Carefully review the information in the section below and, if enrolling in any one of the medical plans listed above, check the box next to I ELECT TO ENROLL:

☐ **I ELECT TO ENROLL** in a (or **MAKE CHANGES TO**) the above health benefits plan and agree to authorize deductions from my salary to cover my share of the cost of enrollment. **I CERTIFY** that the information provided herein is accurate and my listed dependents are eligible family members are defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the above 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 al 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.

To Decline CalPERS Medical: Carefully review the information in the decline medical section below and check the box if you are declining enrollment in medical only:

☐ **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 dates.

Employee Signature:	**Date:**

Please type your full name as signature.