



**CalPERS**  
**GROUP CONTINUATION**  
**COVERAGE**

CONSOLIDATED OMNIBUS BUDGET  
 RECONCILIATION ACT "COBRA"  
 PERS-HBD-85 (Rev 6/13)

**PERS USE ONLY DOCUMENT REFERENCE NUMBER**

**Public Employees' Retirement System**  
**Health Account Services**  
 P.O. Box 942715  
 Sacramento, CA 94229-2715  
**888 CalPERS** (or 888-225-7377)  
 TTY (877) 249-7442 Fax (800) 959-6545

**INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE REVERSE SIDE. PLEASE TYPE**

**PART A: ORIGINAL QUALIFYING EVENT AND DATES**

1. Type of Action <input type="checkbox"/> NEW  <input type="checkbox"/> CHANGE	2. QUALIFYING EVENT <input type="checkbox"/> EMPLOYMENT SEPARATION TIME BASE REDUCTION <input type="checkbox"/> DIVORCE/LEGAL SEPARATION <input type="checkbox"/> CHILD CEASES TO BE A DEPENDENT <input type="checkbox"/> DEATH OF AN EMPLOYEE/RETIREE <input type="checkbox"/> DEPENDENT CONTINUATION-ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE	3. EVENT DATE	4. COBRA ENROLLMENT PERIOD			
			FROM		01	
			TO			

**PART B: ENROLLEE INFORMATION**

5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER)	6. SUBSCRIBER (EMPLOYEE/RETIREE)
SOCIAL SECURITY NUMBER _____	SOCIAL SECURITY NUMBER _____
NAME _____	NAME _____
ADDRESS _____	
CITY, STATE, ZIP _____	

**PART D: DEPENDENT INFORMATION**

DAY PHONE ( ) _____	MARRIED <input type="checkbox"/> YES <input type="checkbox"/> NO	A C C O U N T I O N	LIST OF ALL PERSONS (including self) TO BE ENROLLED: (FIRST) (MI) (LAST)	DATE OF BIRTH			FAMILY RELATIONSHIP <b>SELF</b>
BIRTHDATE _____	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			MO.	DAY	YR	
<b>PART C: CARRIER INFORMATION</b>			SSN				
7. NAME AND ADDRESS OF HEALTH PLAN			(FIRST) (MI) (LAST)				
			SSN				
			(FIRST) (MI) (LAST)				
PLAN CODE: _____	PREMIUM: \$ _____		SSN				
PHONE: _____			(FIRST) (MI) (LAST)				
			SSN				

**PART E: ENROLLMENT CHANGES**

9. NAME OF PRIOR HEALTH PLAN	11. PERMITTING EVENT CODE	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 ABOVE. 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 UNDERSTAND 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 _____	16. HEALTH BENEFITS OFFICER'S SIGNATURE _____
AGENCY CODE _____ UNIT CODE _____	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 Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

### INSTRUCTIONS FOR THE COMPLETION OF THE FORM HBD-85 (08/2011)

- Part A
1. Type of Action check " NEW " if this is a new enrollment.  
Check " CHANGE " if family member is added, deleted, or any plan changes.
  2. Check applicable Original Qualifying Event and Dates.
  3. Provide original event date (separation, date of divorce, etc.).
  4. Original COBRA enrollment period.  
Examples:  
Separation from enrollment 4-15-2010 (Perm. Event) FROM 6-1-2010 TO 11-30-2011  
Child attains age 26 on 6-15-2010 (Perm. Event) FROM 7-1-2010 TO 6-30-2013

Part B: 5. Please provide all requested information.

6. If the COBRA enrollee is a former dependent, the employee/retiree must be identified in box 6.

Part C: 7. Please identify the carrier. The COBRA enrollee must continue the same coverage which he or she had as an employee or as a dependent. Carrier changes are only allowed during the Open Enrollment period or if the enrollee moves into or out of a carrier's geographic service area. The carrier's name, address, and phone number can be found in the annual Health Benefit Summary which is available in all employing agencies. The monthly premium may not exceed 102% of the group rate.

Part D: 8. List all family members to be enrolled, including self.

Action Code: Use "A" to indicate which person is being added (or newly enrolled). Use "D" to indicate if an individual is being deleted from an existing COBRA enrollment. An Action Code is not required when changing carriers.

**IMPORTANT:** The addition or deletion of family members is regulated by time limits which are identical to those for active enrollees (subscribers).

Part E: 9-10 Name and Plan Code of prior health plan if COBRA coverage is being changed.

10-13 to be completed by the Health Benefits Officer

Part F: 14. Signature of COBRA enrollee and date signed.

Part G: 15-16: To be completed by the (former) employing agency. For (former) dependents of retirees, CalPERS is the "employing agency".

**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.**