Print Form

Health Benefit Services Division
P.O. Box 942714
Sacramento, CA 94229-2714
Telecommunications Device for the Deaf - (916) 326-3240
Toll Free: (800) 237-3345 Fax: (916) 326-3935

EMPLOYER ZIP CODE ELECTION

1. I am employed by _____
Name of Employer

My employer's address is:

Street Address: _____

City: _____

ZIP Code: _____

I elect to enroll in _____ plan ("Plan") based on its servicing of an area
Name of HMO
that includes my work address.

2. I understand that unless I obtain Plan pre-approval, I and my enrolled family members must receive non-emergency care from physicians and facilities within the Plan's service area, and that in not doing so I understand that I will incur out-of-pocket costs.

3. I understand that if I am an active member I need to file this Election with my employer's Health Benefits Officer. If I am a working retiree, I need to mail this Election to CalPERS at the address listed below:

CalPERS
Health Benefits Services Division
P.O. Box 942714
Sacramento, CA 94229-2714

My Name: _____
Please print

Signature: _____

Date Signed: _____