State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Direct Payment Authorization

Instructions for completing this form are on pages 3 and 4. Please Print or Type

Section 1: Type of Action and Dates

◯ **New** ◯ **Cancel** ◯ **Cancellation Effective Date** (mm/dd/yyyy)

Section 2: Type of Permitting Event

◯ **Leave of Absence** – **Date from** (mm/dd/yyyy) **Date to** (mm/dd/yyyy)

◯ **Appeal for Dismissal** ◯ **Suspension**

◯ **Permanent Intermittent (Off-Pay)** ◯ **Pending Retirement (Service or Disability)**

◯ **120 Day Employer Paid Survivor Benefits** ◯ **On Worker's Comp (Elected Not to Supplement) or Claim Pending**

◯ **Other- Please Explain:**

Event Date (mm/dd/yyyy) **Enrollment Period From** (mm/01/yyyy) **Enrollment Period to** (mm/dd/yyyy)

Section 3: Enrollee Information

Enrollee (may be different than CalPERS subscriber)

CalPERS ID or Social Security Number **Name** **Date of Birth** (mm/dd/yyyy)

Address (Street) **City** **State** **Zip Code**

Primary Phone Number

Married: ◯ **Yes** ◯ **No**

Gender: ◯ **Male** ◯ **Female** ◯ **Non- Binary**

CalPERS Subscriber (Employee) **CalPERS ID or Social Security Number**

Subscriber Name

Section 4: Dependent Information

List of all persons (including self) to be enrolled

Name (First M.I. Last)	**CalPERS ID or SSN**	**Date of Birth** (mm/dd/ yyyy)	**Family Relationship**

Section 5: Carrier Information

Name and Address of Health Plan (Submit Payment Directly to the Carrier)

Name **Address of Health Plan**

Plan Code **Gross Premium** **Phone Number**

Section 6: Signature of Enrollee

I agree to pay the premium for the coverage directly to the carrier listed in section 5. 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 Enrollee (See Attachment for Privacy Information) **Date Signed** (mm/dd/yyyy)

Section 7: For Employer Use

Agency Name **Employer myCalPERS ID**

Last Active Premium Deduction Pay Period **Permitting Event Date** (mm/dd/yyyy) **Effective Date** (mm/01/yyyy)

Employee Position Information **Agency** **Unit** **Class** **Serial** **CBU**

Health Benefit Officer (Print Name)

Signature **Date** (mm/dd/yyyy) **Phone Number**

Direct Pay Authorization Information

You may continue your health coverage while on temporary leave by paying the entire monthly premium directly to your health plan. You must pay the premium for the pay period in which you return to work.

You are eligible for direct payment if you:

- Are placed on a leave of absence without pay
- Take a temporary disabled leave and do not use sick leave or vacation
- Are waiting for approval of a disability or service retirement
- Are waiting for approval of Non-Industrial Disability Insurance benefits
- Are suspended from your job or you institute legal proceedings appealing a dismissal from your job
- Are a State Permanent Intermittent employee eligible for health benefits but in a non-pay status (note: direct pay may be elected only through the end of your qualifying control period)
- Are a survivor of an employee who died while actively employed and are eligible for the 120-day employer paid survivor benefits

Completing the Direct Payment Authorization form (CalPERS-1008)

Contact your current or former employing agency's Health Benefits Officer/Personnel Office for assistance with completing your form. Forms must be completed before your group coverage terminates. Late forms will not be accepted. In addition, the carrier must receive this form and your payment in order to continue coverage.

While in an off-pay status, you may add or delete family members. To do so, complete and submit a Health Benefits Plan Enrollment for Active Employees Form.

Section 1

Type of Action

a. Select new if this your new/initial enrollment
    i. There cannot be a break in coverage between the end of CalPERS active health coverage and the beginning of Direct Payment enrollment
b. Select cancel if you are canceling your Direct Payment enrollment
    i. You can skip section 2
    ii. Complete section 3 and section 6

Section 2

Type of Permitting Event

a. Select type of Permitting Event
b. Provide original Event Date (Begin Leave of Absence, Death of Employee, etc.)
c. Enter original Direct Payment Enrollment Period

Examples:

- Begin Leave of Absence date 6/15/22 to11/05/22 (Enrollment Period: From 8/1/2022 to 11/30/2022)
- Death of Employee on 6/15/22 (120 Day Enrollment Period: From 7/1/22 to 10/31/22)

Section 3

Provide all requested information. The employer, or retiree will put their information here. For the 120-day survivor benefit, the surviving spouse, domestic partner or the oldest dependent will put their information in this section.

Section 4

List everyone to be enrolled in this section.

Section 5

Identify the carrier. New Direct Payment enrollees must continue enrollment with current health carrier. Carrier changes are allowed during the Open Enrollment period or due to a move. The health plan carrier's name, address, and phone number can be found in the annual Health Benefit Summary available in all employing agencies. Direct Payment premium payment is the responsibility of the enrollee and must be made directly to the carrier. Do not mail premium payments to CalPERS.

Section 6

Signature of enrollee and date signed

Section 7

To be completed by the current or former employing agency's Health Benefits Officer/Personnel Office.

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested by CalPERS' Information Security Office is collected pursuant to the following authority:

- CA Civil Code §56.10
- CA Civil Code §56.11
- CA Civil Code §56.13
- 45 C.F.R. §164.508

The principal purpose the information will be used for is the administration of duties under the Health Insurance Portability and Accountability Act (HIPAA), as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to process your request.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers (SSN) are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided to CalPERS, disclosure is voluntary. Due to the use of SSNs by other agencies for identification purposes, we may be unable to process your request without its disclosure.

Social Security numbers are used for the following purposes:

1. Member / Representative identification
2. Fulfill Member / Representative requests

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy (https://www.calpers.ca.gov/page/privacy-policy), or your rights, please write to:

CalPERS
CalPERS Privacy Officer
400 Q Street
Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).