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 PEMHCA

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 ACEPTED 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 though 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 • 2960 Advantage Road • Sacramento, CA • 95834 - Fax (916) 999-8892