

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 Ti	me of Separation:				
Job Title at Time of Separ	ration:				
Retirement/Separation Da	te:				
Type of retirement (servic	e, disability, etc.):				
Are you currently enrolled	d in the PORAC Ant	hem Blue Cross PPO	Health Plan?	Yes	No
If Yes, Anthem Blue Cros					
Are any dependents cover	ed under your currer	nt health plan?	Yes	No	
If Yes, please provide nar	nes. Dates of birth ar	nd relationship to you	1:		
<u>PLEASE NOTE: You mu</u> To enroll in the CalPER		<u>r (safety personnel t</u> employer must be a			ss Health Plan <u>)</u>
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CalPERS Health	Enrolled Interested	AFLAC	Enrolled Interested	Term Life	Enrolled Interested
		AFLAC		Term Life Cal Casualty Home/Auto	
CalPERS Health	Interested Enrolled Interested	VSP Vision	Interested Enrolled	 Cal Casualty	Interested Enrolled
CalPERS Health Delta Dental	Interested Enrolled Interested or seeking approval f DT BE ACEPTED UN	VSP Vision from IBT: ILESS A COPY OF Y	Interested Enrolled Interested OUR RETIREMEN	Cal Casualty Home/Auto T IDENTIFICATION C	Interested Enrolled Interested CARD IS PROVIDED
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Please return your completed and signed form to:

PORAC IBT	•	2960 Advantage Road	•	Sacramento, CA	•	95834 •	Phone (800) 655-6397	•	Fax (916) 999-8892
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