Life And Disability Enrollment Form
Active Employee
2008 Plan Year Instructions

Enroll online at https://pebb.benefits.oregon.gov/members

Complete this form to enroll in life, accidental death and dismemberment, and/or disability coverage through the Public Employees' Benefit Board (PEBB) or to make a change during Open Enrollment.

SECTION A – EMPLOYEE INFORMATION

- Complete all items in this section.

SECTION B – LIFE INSURANCE PLAN ELECTIONS

- Check the appropriate box for your enrollment selections.
    - **B.1, B.3:** If you are adding an individual by PEBB Affidavit of Domestic Partnership or PEBB Affidavit of Dependency you must submit the appropriate affidavit **within 5 business days** of this enrollment election. If not, coverage for the individual by affidavit will terminate retroactive to the effective date.
    - **B.2, B.3:** If you were a PEBB member and you ported your previous optional life insurances check the box and contact your agency/university benefits office for instructions on enrollment.
      B.4: If you are enrolling a Domestic Partner check the appropriate box and submit appropriate forms.

SECTION C – ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) ELECTION

- Check the appropriate box for the tier and coverage elections.

SECTION D – DISABILITY INSURANCE ELECTIONS

- Check the appropriate box for your selection on Short Term Disability.
- Check the appropriate box for your selection on type and coverage level for Long Term Disability.

SECTION E – BENEFICIARY DESIGNATION

- You are the beneficiary for Spouse or Domestic Partner Optional Life and Dependent Life coverage.
- The total of all primary beneficiaries must equal 100%.
- The total of all contingent beneficiaries must equal 100%.
- You may complete or change your beneficiary designation at any time either online at https://pebb.benefits.oregon.gov/members or by form. The Designation of Beneficiaries form is available online at www.oregon.gov/DAS/PEBB.

SECTION F – EMPLOYEE SIGNATURE AND AUTHORIZATION

- Read this section carefully, sign and date the form.
- Make a copy for your records and submit the completed form to your agency or university benefits office.

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Life and Disability Enrollment Form
Active Employee 2008 Plan Year

SECTION A - EMPLOYEE INFORMATION

☐ NEW EMPLOYEE HIRE DATE :			☐ OPEN ENROLLMENT
LAST	FIRST	MI	ID NUMBER (SSN, OUS#, Benefit #)
DATE OF BIRTH (MM-DD-YYYY)	GENDER ☐ FEMALE ☐ MALE		
RESIDENCE ADDRESS ☐ New Address	CITY	STATE	ZIP
	COUNTY	HOME PHONE	
MAILING ADDRESS (if different from above) ☐ New Address	AGENCY	WORK PHONE	
E-MAIL			

SECTION B - LIFE INSURANCE PLAN ELECTIONS

Basic Life Insurance is $5,000 employee coverage only. You are automatically enrolled when you enroll in medical and dental plans.

B.1: Dependent Life is $5,000 for each eligible dependent (including spouse and/or domestic partner). You do not need to enroll your eligible dependents in any PEBB plans for them to be eligible for this coverage. If coverage is for an individual by affidavit see instructions.

☐ New Coverage ☐ Cancel Coverage

B.2: Employee Optional Life: ($20,000 increments to $400,000).

☐ Check this box if you are a previous state employee and you ported your previous employee life insurance plan with Standard. Contact your agency/university benefits office for instructions on enrollment.

New Hire Options:(medical history statement required for amounts over $20,000)

☐ Guarantee Issue - $20,000 (newly eligible only)

☐ Enroll - **Total** Requested Amount: $_____
(include the $20,000 guarantee issue)

Open Enrollment Options:(medical history statement required for increase and enrollment)

☐ Change Coverage: From $_____ to $_____ **TOTAL**

☐ Cancel Coverage

☐ Enroll – Total Requested Amount $_____

When a medical **history statement** is required you must submit **within 5 business days** of this enrollment selection. If not, your request for insurance will be canceled.

B.3: Spouse or Domestic Partner Optional Life: ($20,000 increments to $400,000.

☐ Check this box if you are a previous state employee and you ported your previous spouse/domestic partner life insurance plan with Standard. Contact your agency/university benefits office for instructions on enrollment.

B.4: Domestic Partner – see instructions. Check the appropriate box. ☐ Domestic Partner by PEBB Affidavit of Domestic Partnership

☐ Domestic Partner by Certificate of Registered Domestic Partnership

Name: _____ ☐ Spouse ☐ Domestic Partner (see instructions)

ID# (SSN, University ID, Benefit Number): _____ **Date of Birth:** _____

New Hire Options:(medical history statement required for amounts over $20,000)

☐ Guarantee Issue - $20,000 (newly eligible only)

☐ **Total** Requested Amount: $_____
(include the $20,000 guarantee issue)

Open Enrollment Options: (medical history statement required for increase and enrollment)

☐ Change Coverage: From $_____ to $_____ **TOTAL**

☐ Cancel Coverage

☐ Enroll – Total Requested Amount $ _____

When a medical **history statement** is required you must submit **within 5 business days** of this enrollment selection. If not, your request for insurance will be canceled.

SECTION C - ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) ELECTION

Accidental Death & Dismemberment (AD&D): ($50,000 increments to $500,000)

Coverage Tier:	***Coverage Choice:***
☐ Employee Only	☐ New Coverage (indicate amount) $_____
☐ Employee and Dependents	☐ Change Coverage Amount From $_____ to $_____
	☐ Cancel Coverage

SECTION D - DISABILITY INSURANCE ELECTION

☐ **Short Term Disability**	☐ **Long Term Disability**	
Coverage Type:	***Coverage Type:***	***Waiting Period - Coverage Level***
☐ New Coverage	☐ New Coverage	☐ 90 day 60%
☐ Cancel Coverage	☐ Change in Coverage	☐ 90 day 66 2/3%
	☐ Cancel Coverage	☐ 180 day 60%
		☐ 180 day 66 2/3%

SECTION E - BENEFICIARY DESIGNATION

Select one:

☐ I elect the standard designation with no beneficiaries listed. (Creates a chain of beneficiaries that automatically allows for future marriages, divorces, births, deaths, or adoptions within your family as established by Oregon law.

☐ I designate the following beneficiary (ies). Attach additional sheet if necessary.

Name of Beneficiary or Trust	DOB	Relationship	Primary or Contingent	Percentage
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	

SECTION F - EMPLOYEE SIGNATURE AND AUTHORIZATION

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the elections I made are in effect, pending approval by Standard Insurance Company (if required), as long as I continue to meet the PEBB eligibility requirements or until I elect to change them subject to the terms of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB life and disability benefits program. I authorize my employer to deduct in advance each month from any earned or accrued wages due me, such amount as is necessary to pay the premium rates for the coverage I elected.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

This form supersedes all forms and submissions I previously made for PEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject o penalty for perjury.

_____ _____

Employee Signature Date

"PEBB Use Only"

Approved by (initials): Date: Approved change effective date: PDB updated by (initials):