PEBB Life And Disability Update Form
Midyear Change Request
Instructions
www.oregon.gov/DAS/PEBB

Complete this form to make midyear changes to your Life, Disability and/or Accidental Death and Dismemberment (AD&D) coverage. Please refer to the PEBB Benefits Handbook or web site for midyear change criteria.

- Submit one form per qualified status change (QSC)
- You will be notified of the coverage effective date.
- 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.
- If applicable you must also submit documentation of an adoption agreement.

SECTION A – EMPLOYEE OR SUBSCRIBER INFORMATION

- Complete all items in this section.
- If making an address change only, complete Sections A and D, check the New Address box in Section A.
- If making a name change only, complete Sections A and D.

SECTION B – QUALIFIED STATUS CHANGE INFORMATION

B.1 Select the QSC and enter the QSC date.

SECTION C – REQUESTED ENROLLMENT OR CHANGES

- Complete the appropriate sections if you wish to enroll or change your current coverage. All previous coverages will continue unless you cancel or change the level of coverages.
  C.1 Life Insurances
  C.2 Accidental Death & Dismemberment (AD&D)
  C.3 Disability Insurances

SECTION D – EMPLOYEE SIGNATURE AND AUTHORIZATION

- Read sign and date the form.
- Make a copy for your records and submit. **Sending your forms to the wrong address will delay your change**.

Active and Semi Independent Agency Employees:

Within 60 days of QSC to: Agency/University Payroll,
Personnel or Benefit Office

Beyond 60 days of QSC to: PEBB
1225 Ferry St. SE
Salem, OR 97301-3802
Salem (503)-373-1102
Toll-free (800)-788-0520

COBRA and other Self-Pay Participants Only to:
BenefitHelp Solutions (BHS)
PO Box 67240
Portland, OR 97268-1240
Portland (503)-765-3581
Toll-free (800)-556-3137

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SECTION A - EMPLOYEE INFORMATION

Change of: ☐ **Name Only** ☐ **Address Only**

LAST NAME	FIRST NAME	MI	ID NUMBER (SSN, University ID, 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

EMAIL ADDRESS

SECTION B - QUALIFIED STATUS CHANGE (QSC) INFORMATION

B.1 Select the QSC and enter the QSC date.

☐ Marriage Date:_____

☐ Meet domestic partner eligibility Date:_____
Check a box.
- ☐ Domestic Partner by **PEBB Affidavit of Domestic Partnership**, attach affidavit (see instructions).
- ☐ Domestic Partner by **Certificate of Registered Domestic Partnership.** Complete this form only.
- ☐ Change PEBB Domestic Partnership by Affidavit to Certificate of Registered Domestic Partnership.

☐ Divorce, Annulment Date:_____

☐ Birth Date: _____

☐ Adoption or placement for adoption Date:_____

☐ Dependent(s) gains eligibility Date:_____

☐ Death of a dependent Date:_____

☐ Termination of domestic partnership Date: _____.
Check a box.
- ☐ If domestic partner was added by **PEBB Affidavit** you must attach the Termination of Domestic Partnership.
- ☐ If domestic partner was added by **Certificate of Registered Domestic Partnership.** Complete this form only.

☐ Dependent ceases to meet eligibility Date:_____

☐ Employment status change (describe):

_____ Date:_____

☐ Other (describe)

_____Date:_____

SECTION C – REQUESTED ENROLLMENT OR CHANGES

C.1 LIFE INSURANCE All previous coverages will continue unless you cancel or change the level of insurance.

Dependent Life ($5,000 coverage) ☐ New coverage ☐ Cancel

You do not need to enroll your eligible dependents in any other PEBB plans for them to be eligible for this coverage.

Optional Employee 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 coverage amount $ _____

☐ Change coverage from $_____ to $_____ **TOTAL** (include existing coverage)

☐ Cancel

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.

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Optional Spouse or Partner 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

Spouse or Partner's Name: _____ **ID#** (SSN, University ID, Benefit Number): _____
Date of Birth: _____

☐ Guarantee Issue - $20,000 (newly eligible only)
☐ **Total** Requested Amount: $_____
(include the $20,000 guarantee issue)

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

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.

C.2 Accidental Death and Dismemberment (AD&D) ($50,000 increments to $500,000)

Coverage Tier:

☐ Employee only

☐ Employee and dependents

Coverage Choice:

☐ New coverage (indicate amount) $_____

☐ Change coverage amount from $_____ to $_____

☐ Cancel

C.3 DISABILITY INSURANCE

Short Term Disability

Coverage Type:

☐ New coverage

☐ Cancel

Long Term Disability

Coverage Type: Level

☐ New coverage

☐ Change in coverage

☐ Cancel

Waiting Period Coverage

☐ 90 day - 60%

☐ 90 day - 66 2/3%

☐ 180 day - 60%

☐ 180 day - 66 2/3%

SECTION D - 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 benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments deducted from my pay, unless I self pay premiums. If I self-pay the premiums, I agree to submit monthly payments by the date specified, or my coverage will terminate.

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 updates your 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 to penalty for perjury.

_____ _____
Employee Signature Date

"PEBB Use Only"

Approved by PEBB (initials) _____ Date:_____ Effective Date:_____ PDB updated by (initials)_____