PEBB LIFE & LONG TERM CARE INSURANCE
ROLL OVER FORM Instructions
www.oregon.gov/DAS/PEBB

Complete this form if you and your spouse or domestic partner are PEBB members and you want to roll over their current optional life insurances and /or Long Term Care to your active coverage. You may take this action if your spouse or domestic partner:

- retires;
- terminates state employment;
- commences active military leave;
- terminates domestic partnership.
- Your divorce is final

You pay for all requested roll over plan premiums through your monthly payroll deductions. Detailed information is available in the PEBB Benefits handbook or on the web site.

SECTION A - SUBSCRIBER INFORMATION (the person that will be paying the insurance premiums)

- Complete all items in this section.

SECTION B - SPOUSE OR DOMESTIC PARTNER INFORMATION (the person that will no longer be paying insurance premiums)

- Complete this section.

B-1: Check the appropriate box and include the date.

SECTION C – ROLL OVER OPTIONAL LIFE INSURANCE PLAN
Select the type of Optional Life insurance and the amount you wish to roll over to your monthly payroll deductions.
Note:

- The amount must be in increments of $20,000 and cannot be more then the amount currently in effect.
- The total amount cannot exceed $400,000 per individual.

SECTION D – ROLL OVER LONG TERM CARE PLAN

- Select the type of Long Term Care coverage you wish to roll over to your monthly payroll deductions.

SECTION E - SPOUSE OR DOMESTIC PARTNER SIGNATURE AND CERTIFICATION

- Read, sign and date

Note: If this is due to divorce or termination of domestic partnership, the signature is not required.

SECTION F - SUBSCRIBER SIGNATURE AND CERTIFICATION

- Read, sign and date the form.
- Make a copy for your records and submit to the subscriber's agency/university payroll or benefit office.

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PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

LIFE INSURANCE & LONG TERM CARE ROLL OVER FORM

SECTION A - SUBSCRIBER INFORMATION (the person that will continue to pay insurance premiums)

LAST NAME	FIRST NAME		MI
DATE OF BIRTH (MM-DD-YYYY)	ID NUMBER (SSN, University ID, Benefit Number)		
ADDRESS	CITY	STATE	ZIP
AGENCY NAME OR NUMBER	HOME PHONE	WORK PHONE	
E-MAIL ADDRESS			

SECTION B - SPOUSE OR DOMESTIC PARTNER INFORMATION (the person that will no longer pay the insurance premiums)

B-1: See Instructions

☐ RETIREMENT : ☐ TERMINATION : ☐ DIVORCE or DP TERM: ☐ MILITARY LEAVE:

LAST NAME	FIRST NAME		MI
DATE OF BIRTH (MM-DD-YYYY)	ID NUMBER (SSN, University ID, Benefit Number)		
ADDRESS	CITY	STATE	ZIP
AGENCY NAME OR NUMBER	HOME PHONE		
E-MAIL ADDRESS			

SECTION C - ROLL OVER LIFE INSURANCE PLAN COVERAGE

☐ **Roll over optional employee life insurance coverage from my current/former spouse or domestic partner to my monthly payroll deductions.**

☐ Full Amount ☐ Reduced Amount: $_____

☐ **Roll over optional spouse or domestic partner life insurance from my current/former spouse or domestic partner to my monthly payroll deductions.**

☐ Full Amount ☐ Reduced Amount: $_____

SECTION D - ROLL OVER LONG TERM CARE INSURANCE PLAN DEDUCTION

☐ **Roll over employee Long Term Care from my current/former spouse or domestic partner to my monthly payroll deductions.**

☐ **Roll over spouse or domestic partner Long Term Care from my current/former spouse or domestic partner to my monthly payroll deductions.**

SECTION E - SPOUSE OR DOMESTIC PARTNER SIGNATURE AND CERTIFICATION

I authorize the release of information regarding my optional life plan coverage and/or long term care plan enrollment to the above named subscriber. I authorize the use of this information only as needed to complete the request for roll over of these benefits.

_____ _____

Spouse or Domestic Partner Signature Date

SECTION F - SUBSCRIBER SIGNATURE AND CERTIFICATION

I understand the elections I made are in effect, pending approval by The Standard Insurance Company and/or UnumProvident (if required) and as long as eligibility requirements are met, until I elect to change the elections, subject to the provisions of each plan. Benefit costs will be taken out of my pay by monthly payroll deduction. I have read the benefit materials and understand the limitations and qualifications of the PEBB Benefit Program.

_____ _____

Subscriber Signature Date

"PEBB Use Only"

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

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