PEBB Medical And Dental Update Form
Midyear Change Request
Instructions
www.oregon.gov/DAS/PEBB

Complete this form to make midyear changes to your medical and/or dental insurance. 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.

SECTION A - EMPLOYEE/SUBSCRIBER INFORMATION

- Complete all items in this section.
- If making a change to your address 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 - QUALIFED STATUS CHANGE (QSC) INFORMATION

B.1 Select the change requested.
B.2, B.4, and B.5 Select the QSC and enter the QSC date.
Note: Processing of your request will not begin without the QSC date.
B.2 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 will terminate retroactive to the effective date.
B.3 You must certify that your dependent children between the ages of 19 up to 24 continue to meet the PEBB eligibility requirements**. If you do not certify, your dependent's enrollments will not be processed.** .

SECTION C - COORDINATION OF BENEFITS

- Complete this section if you or your dependents have other coverage.
- You must attach a copy of the Medicare card for each individual enrolled in Medicare.

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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PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Medical And Dental Update Form
Midyear Change Request

SECTION A - EMPLOYEE/SUBSCRIBER 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

E-MAIL ADDRESS

SECTION B - QUALIFIED STATUS CHANGE (QSC) INFORMATION

B.1 Change you are requesting to your coverage:

☐ **Add a Dependent - Complete Section B.2**
☐ **Remove a Dependent – Complete Section B.4**
☐ **Change your medical or dental plan – Complete Section B.5**

B.2 Add a dependent or domestic partner mid-year

☐ Marriage Date:_____

☐ Met 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.

☐ Birth Date:_____

☐ National Medical Support Notice (NMSN) Date:_____

☐ Adoption or placement for adoption Date: _____

☐ Dependent meets eligibility. If child by Affidavit (Dependency or Domestic Partnership) you must attach the appropriate affidavit (see instructions) Date:_____

☐ Involuntary loss of other group coverage. Date:_____

☐ Employment status change. Date:_____

☐ Other reason (describe): Date:_____
_____
_____
_____

List *only* dependents added by this change. Check plan selections if applicable. Do not list current dependents.
Relationship Key: SP=Spouse, **DP**=Domestic Partner, **CH**=Employee and/or Spouse's child, **DP CH**=Domestic Partner's child, **AFF CH**=Child by Affidavit

Last Name	First Name	MI	ID Number	Birth Date	Relationship	Gender F M	Prior PEBB Member Yes No	Plan Med Dental
						☐ ☐	☐ ☐	☐ ☐
						☐ ☐	☐ ☐	☐ ☐
						☐ ☐	☐ ☐	☐ ☐
						☐ ☐	☐ ☐	☐ ☐

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B.3 Dependent certification – see instructions. Detailed eligibility information is available in the 2008 PEBB Handbook or at www.oregon.gov/DAS/PEBB.

☐ I certify that all my dependent children, between the ages of 19 – 24 meet the eligibilty requirements for enrollment in the PEBB plans.

B.4 Remove a dependent or domestic partner midyear:

☐ Divorce, Annulment Date:_____

☐ Death of a dependent Date:_____

☐ Termination of domestic partnership Date: _____ Check a box.

☐ If the domestic partner was added by **PEBB Affidavit** – You must attach the PEBB Termination of Domestic Partnership.

☐ If the domestic partner was added under **the Certificate of Registered Domestic Partnership** – Complete this form only.

☐ Dependent ceases to meet eligibility Date:_____

☐ Dependent gains other group coverage Date:_____

☐ Employment status change (describe): Date:_____

REQUIRED: NAME AND ADDRESS OF DELETED DEPENDENT(s) FOR COBRA PURPOSES:

1._____

_____

_____

_____

2. _____

_____

_____

3._____

_____

_____

B.5 Change benefits midyear:

☐ **OPT OUT OF PEBB MEDICAL PLANS** due to gaining other group medical coverage. If requested you must provide supporting documentation. **Must complete Section C**.
Date: _____

☐ **ENROLL IN PEBB MEDICAL PLANS** from opt out due to loss of other group medical coverage.
Date: _____

☐ **CHANGE MEDICAL OR DENTAL PLANS** due to:

☐ National Medical Support Notice (NMSN) Date: _____

☐ Employment status change (i.e. full time to part time) Date: _____

☐ Move out of current plan's service area. Date: _____

Medical (select one):	Full-Time Plan	Part-Time Plan
☐ Opt out		
☐ Kaiser HMO	☐	☐
☐ Kaiser Added Choice	☐	☐
☐ Providence Choice PPO	☐	☐
☐ Regence BCBSO PPO	☐	☐
☐ Samaritan Select PPO	☐	☐
☐ Decline all PEBB plans		

Dental (select one):

☐ Kaiser Permanente Full-time
☐ ODS Preferred Option
☐ ODS Traditional
☐ Willamette
☐ ODS Part-time & Retiree
☐ Kaiser Part-time & Retiree

SECTION C - COORDINATION OF BENEFITS

Are any of the new dependents covered through another PEBB ☐ or another group ☐ plan? If yes, complete the following information:

☐ Medical ☐ Dental ☐ Pharmacy

Carrier	Group No
Policy No	Employer
Subscriber's Name	Effective Date: (mm-dd-yyyy)

Medicare Information – see instructions.

☐ I am covered by Medicare ☐ My dependent(s) is covered by Medicare

SECTION D - EMPLOYEE/SUBSCRIBER 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/Subscriber Signature Date

"PEBB Use Only"

Approved By PEBB (initials): Date: Effective date: PDB updated by (initials):