

PEBB Medical and Dental Enrollment Form
Non-Medicare Eligible Retiree & Non-Medicare Eligible Dependents
2008 Plan Year Instructions
www.oregon.gov/DAS/PEBB

Complete this form to enroll in retiree medical and/or dental coverage through the Public Employees' Benefit Board (PEBB) or to make a change in coverage during a Plan Change period. **If you or any of your dependents are eligible for Medicare, PEBB plan enrollment is not available.**

SECTION A - RETIREE OR SUBSCRIBER INFORMATION (subscriber is the member who is not the State of Oregon retiree but who is eligible to continue a PEBB plan)

- Complete each item in this section.
- **New Retiree only:** include your retirement date and the date your active insurance coverage terminated.

SECTION B - MEDICAL AND DENTAL PLAN ELECTIONS

- Check the box of the plan(s) you are selecting.
 - B.1:** Medical:
 - B.2:** Dental:
- Note:** If you did not previously have a medical or dental plan, you cannot add a medical or dental plan during a Plan Change period.

SECTION C - DEPENDENT INFORMATION AND PLAN SELECTION

- Complete each item in this section.
- You cannot add dependents during a Plan Change period.
- List all eligible dependents. **Dependents not listed will not be covered.**

SECTION D - DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

- Check the appropriate box.
 - D.1:** 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.**
 - D.2:** You must attach a copy of the Medicare card for each individual enrolled in Medicare.

SECTION E - RETIREE OR SUBSCRIBER SIGNATURE AND AUTHORIZATION

- Read this section carefully. Sign and date the form.
- Make a copy for your records and submit to:

BenefitHelp Solutions (BHS)
PO Box 67240
Portland, OR 97268-1240
Portland (503)-765-3581
Toll-free (800)-556-3137



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2008 Plan Year**

SECTION A - RETIREE/SUBSCRIBER INFORMATION (subscriber is not the State of Oregon retiree but eligible to continue)

<input type="checkbox"/> New Retiree		Retirement Date:	Active Coverage Term Date:	<input type="checkbox"/> Plan Change Period	
<input type="checkbox"/> Subscriber (other than retiree)					
LAST	FIRST	MI	ID NUMBER (SSN, University ID, Benefit Number)		
DATE OF BIRTH (MM-DD-YYYY)			GENDER	<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE
RESIDENCE ADDRESS		<input type="checkbox"/> New Address		CITY	STATE
				COUNTY	HOME PHONE
MAILING ADDRESS (if different from above)		<input type="checkbox"/> New Address		AGENCY (Former)	E-MAIL ADDRESS

SECTION B - MEDICAL AND DENTAL PLAN ELECTIONS

B-1 Medical (select one):	Full-Time Plan	Part-Time Plan	B-2 Dental (select one, only if you have had continuous dental coverage):
	<input type="checkbox"/> No Coverage	<input type="checkbox"/> No Coverage	
<input type="checkbox"/> Kaiser HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ODS Part-time and Retiree
<input type="checkbox"/> Kaiser Added Choice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ODS Preferred Option
<input type="checkbox"/> Providence Choice PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ODS Traditional
<input type="checkbox"/> Regence BCBSO PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Willamette
<input type="checkbox"/> Samaritan Select PPO	<input type="checkbox"/>	<input type="checkbox"/>	

SECTION C - DEPENDENT INFORMATION AND PLAN SELECTION

If you or a dependent is Medicare eligible, you are not eligible for PEBB coverage. List all eligible dependents you wish to cover and check plan selections. If covering a domestic partner, partner's children, or dependent by affidavit, a completed affidavit must be attached or on file. **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		Prior PEBB Member		Plan	
						F	M	Y	N	Med	Dental
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION D – DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

D.1 Dependent certification – see instructions. Detailed eligibility information is available at www.oregon.gov/DAS/PEBB or in the 2008 PEBB Handbook.

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

D.2 Medicare Information – see instructions

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

SECTION E - RETIREE/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. I agree to self-pay 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 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 to penalty for perjury.

Retiree/Subscriber Signature _____ Date _____

Approved by PEBB (initials):	Date:	"PEBB Use Only"	Effective Date:	PDB updated by (initials):
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