PEBB Medical And Dental Enrollment Form Self Pay Participants 2008 Plan Year Instructions www.oregon.gov/DAS/PEBB

Complete this form to enroll for medical and dental coverage through the Public Employees' Benefit Board (PEBB) or to make a change in coverage during Open Enrollment.

SECTION A – PARTICIPANT INFORMATION

- Complete each item in this section.
- Continuing participation: check the Open Enrollment box.

SECTION B – MEDICAL AND DENTAL PLAN ELECTIONS (You must have medical to enroll in dental)

- Check the box for the plan(s) you are selecting.
 - **B.1**: Medical: **Note:** Blind B

Note: Blind Business Enterprise Participants: medical plan enrollment **only. B.2**: Dental:

SECTION C – DEPENDENT INFORMATION AND PLAN SELECTION

- Complete each item in this section.
- List all eligible dependents. **Dependents not listed will not be covered.**
- 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.
- Additional information and forms are available from BenefitHelp Solutions, the PEBB web site, and in the 2008 PEBB Benefits Handbook.

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 check the appropriate box when adding a Domestic Partner.
 - **D.3:** You must attach a copy of the Medicare card for each individual enrolled in Medicare.

SECTION E – PARTICIPANT 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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SECTION A - PARTICIPAN	NT INFOR	VIAII	ON									
vou hogeme eligibile:					/J1 Visa 🔲 Blind Business Enterprise					Open Enrollment		
you became engibile.		□ Foster Parent – you must attach a										
LAST	FIRST				MI ID NUMBER (SSN, University ID, Benefit Number)							
DATE OF BIRTH (MM-DD-YYYY)					GENDER 🗌 FEMALE 🗌 MALE							
RESIDENCE ADDRESS					CITY		STATE		ZIP			
					COUNTY HOME PHONE							
MAILING ADDRESS (if different from above)						AGENCY						
E-MAIL												
SECTION B - MEDICAL AND DENTAL PLAN ELECTIONS (Must have Medical Coverage to enroll in a Dental Plan):												
B-1 Medical (select one): B-2 Dental (select one): Not all participants are eligible for dental.												
□ No Coverage □ Regence BCBSO PPO Please see instructions.												
	Samaritan Select PPO				No Coverage				ODS Preferred Option			
Kaiser Added Choice						Kaiser Permanente			ODS Traditional			
Providence Choice PPO												
SECTION C - DEPENDENT			N AND PLAN SE	LECT	ION							
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 F	irst Name	МІ	ID Number	Birth	Date	Relationship	Gen	dor	Prior PEB Member		Plan	
Last Name	IISt Name	IVII		Dirti	Dale	Relationship	F	M	Y N		Dental	
										, , , , , , , , , , , , , , , , , , , ,		
SECTION D - DEPENDEN	T CHILDR	EN C		AND N	IEDICA	RE INFOR	MATION	N				
D.1 Dependent certification -see	e instruction	s. De	etailed eligibity inform	nation is	availabe a	at <u>www.orego</u>	n.gov/DA	S/PEBB	<u>3</u> or in the 20	08 PEBB H	andbook.	
\Box I certify that all my dependent c	hildren, betw	een the	e ages of 19 – 24 me	et the e	ligiblity red	quirements fo	r enrollme	nt in th	e PEBB plan	s.		
D.2 Domestic Partner – see instr	uctions.		Domestic Pa	artner b	y PEBB Af	fidavit of Dor	nestic Parl	inershi	0			
			Domestic Pa	artner by	v Certificat	e of Register	ed Domes	tic Par	tnership			
Domestic Partner by Certificate of Registered Domestic Partnership D.3 Medicare Information – see instructions.												
SECTION E - PARTICIPANT 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 gualifications 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 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.												
Participant Signature			"DED	B Use C)nlv"	Date						
			PEBI	b Use C	лпу							
Approved by PEBB (initials):	Dat	e:	Effect	ive date	:			PDE	3 updated by	(initials)		