# PEBB Medical And Dental Enrollment Form
# COBRA Participant
# 2009 Plan Year Instructions
www.oregon.gov/DAS/PEBB

Complete this form to make a change in coverage during Open Enrollment.

**SECTION PARTICIPANT INFORMATION -** Complete each item in this section.

**SECTION B – MEDICAL AND DENTAL PLAN ELECTIONS**

- Check the box of the plan(s) you are selecting.
  **B.1:** Medical: Select one. COBRA part-time plans are only available to individuals who were previously enrolled in an active part-time plan.
  **B.2:** Dental: Select one. COBRA part-time plans are only available to individuals who were previously enrolled in an active part-time plan.

**SECTION C – DEPENDENT INFORMATION AND PLAN SELECTION**

- Complete each item in this section.
- List all eligible dependents you want to cover. **Dependents not listed on this form 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 five business days** of this enrollment election. If you do not, coverage for the individual added by affidavit will terminate retroactive to the effective date.
- Additional information and forms are available from BenefitHelp Solutions and on the PEBB web site.

**SECTION D – DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION**

- Check the appropriate box.
  **D.1:** You must certify that your dependent children 19 to 24 continue to meet the PEBB eligibility requirements**. If you do not certify, your dependent's enrollments will not be processed.**
  **D.2:** Check the appropriate box on the type of enrollment 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

# Medical And Dental Enrollment Form
# COBRA Participants
# 2009 Plan Year

## SECTION A - PARTICIPANT INFORMATION

| LAST | FIRST | MI | ID NUMBER (SSN, University, or 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 | | | |
| E-MAIL ADDRESS | | | |

## SECTION B – MEDICAL AND DENTAL PLAN ELECTIONS

***B-1 Medical (select one):***

| | | Full-Time Plan | Part-Time Plan |
|---|---|---|---|
| ☐ | No Coverage | | |
| ☐ | Kaiser HMO | ☐ | ☐ |
| ☐ | Kaiser Added Choice | ☐ | ☐ |
| ☐ | Providence Choice PPO | ☐ | ☐ |
| ☐ | Regence BCBSO PPO | ☐ | ☐ |

***B-2 Dental (select one):***

☐ No Coverage
☐ Kaiser Permanente
☐ ODS Preferred
☐ ODS Traditional
☐ Willamette
☐ ODS Part-time & Retiree
☐ Kaiser Part-time & Retiree

## SECTION C – DEPENDENT INFORMATION

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 F | Gender M | Prior PEBB Member Y | Prior PEBB Member N | Plan Medical | Plan Dental |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## 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 in the Summary Plan Document.

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

**D.2 Domestic Partner**

☐ Domestic Partner by PEBB Affidavit of Domestic Partnership – See Section C instructions.
☐ Domestic Partner by Certificate of Registered Domestic Partnership

**D.3 Medicare Information – see instructions.**

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

## 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 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.

______________________________ Participant Signature

____________________ Date

"PEBB Use Only"

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