PEBB Medical and Dental Enrollment Form
Active Employee
2009 Plan Year Instructions

Enroll online at https://pebb.benefits.oregon.gov/members

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

SECTION EMPLOYEE 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:
- Full-time employees are eligible for full-time plans only.
- Part-time and job share employees are eligible for either full-time or part-time plans.

B-2: Dental:
- Full-time employees are eligible for full-time plans only.
- Part-time and job share employees are eligible for either full-time or part-time plans.
- Employees enrolled in a medical plan (this includes Opt Out) must enroll in a dental plan for at least "employee only".

SECTION C – DEPENDENT INFORMATION AND PLAN ELECTION

- Complete each item in this section. List all eligible dependents. **Dependents not listed will not be covered.**
  - **C-1:** You must certify that dependent children ages 19 to 24 continue to meet the PEBB eligibility requirements**. If you do not certify, your dependent's enrollments will not be processed.**
  - **C-2:** Check the appropriate box on the enrollment type when adding a Domestic Partner.

- **NOTE:** 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.

- Contact your agency payroll, personnel office, university benefits office or PEBB at (503)-373-1102 or (800)-788-0520 if you need a form. Detailed information is available on the PEBB web site at www.oregon.gov/DAS/PEBB in the Summary Plan Document.

SECTION D – COORDINATION OF BENEFITS INFORMATION

- Complete this section if you or your dependents have other coverage.
- If your election is Medical Opt Out you must provide proof of coverage under another employer-sponsored group medical insurance plan **within five business days** of this enrollment. If you do not, coverage will be defaulted to Regence BCBSO for the employee only retroactive to the effective date.
- You must attach a copy of the Medicare card for each individual enrolled in Medicare.

SECTION E – EMPLOYEE SIGNATURE AND AUTHORIZATION

- Read this section carefully.
- Sign and date the form.
- Make a copy for your records.
- Submit the completed form to your agency or university benefits office.

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SECTION A - EMPLOYEE INFORMATION

☐ NEW EMPLOYEE HIRE DATE:			☐ OPEN ENROLLMENT
LAST	FIRST	MI	ID NUMBER (SSN, University, 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			

SECTION B - MEDICAL AND DENTAL PLAN ELECTIONS

B-1 Medical (select one):	Full-Time Plan	Part-Time Plan	**Alternative choice:**	**B-2 Dental (select one):**
☐ Kaiser HMO	☐	☐	☐ Opt Out – You must have other group coverage to be eligible. See Section D for instructions.	☐ Kaiser Traditional Full-Time
☐ Kaiser Added Choice	☐	☐		☐ ODS Preferred Option
☐ Providence Choice PPO	☐	☐	☐ Decline – You waive rights to the benefit amount and enrollment in **all** PEBB programs. You will not receive a portion of the benefit amount as cash.	☐ ODS Traditional
☐ Regence BCBSO PPO	☐	☐		☐ Willamette
				☐ ODS Part-time & Retiree
				☐ Kaiser Traditional Part-time & Retiree

SECTION C - DEPENDENT INFORMATION AND PLAN SELECTION

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 (see Section C)**. 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 Y N	Enroll In Med Dental
						☐ ☐	☐ ☐	☐ ☐
						☐ ☐	☐ ☐	☐ ☐
						☐ ☐	☐ ☐	☐ ☐
						☐ ☐	☐ ☐	☐ ☐
						☐ ☐	☐ ☐	☐ ☐

C.1 Dependent certification – see Section C 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.

C.2 Domestic Partner – see Section C instructions.

☐ Domestic Partner by PEBB Affidavit of Domestic Partnership
☐ Domestic Partner by Certificate of Registered Domestic Partnership

SECTION D - COORDINATION OF BENEFITS INFORMATION

Are you or any of your dependents covered through another PEBB ☐ or another group ☐ plan? If yes, complete the following information. If you are selecting Medical Opt Out you must provide proof of coverage within five business days of this enrollment.

Plan Type: ☐ Medical ☐ Dental ☐ Prescription Drug

Carrier		
Policy Number	Group Number	
Subscriber's Name	Employer	Effective Date

Medicare Information – attach copy of Medicare card.

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

SECTION E - EMPLOYEE SIGNATURE AND AUTHORIZATION

E-1: If you receive a benefit amount from your employer, premiums for medical, dental and employee life coverage (up to $50,000) will be **automatically** deducted on a before-tax basis. If you DO NOT want premiums deducted on a before-tax basis, initial here _____.

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.

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.

_____ _____
Employee Signature Date

"PEBB Use Only"

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