PEBB Medical and Dental Enrollment Form
Non-Medicare Eligible Retiree & Non-Medicare Eligible Dependents
2009 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: Select one.
  B.2: Dental: Select one.
  Note (New Retiree):
  - You may continue your current plan or you may change plans. You may enroll in a full-time or part-time plan if you meet plan criteria.

  Note (Open Enrollment):
  - If you did not previously have a medical or dental plan, you cannot add a medical or dental plan during a Plan Change (Open Enrollment) 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 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: 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

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

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Non-Medicare Eligible Retiree & Non-Medicare Eligible Dependents
2009 Plan Year

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

☐ New Retiree Retirement Date: Active Coverage Term Date: ☐ Plan Change Period

☐ Subscriber (other than retiree)

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 (Former) | 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 Traditional Full-time
- ☐ ODS Part-time and Retiree
- ☐ ODS Preferred Option
- ☐ Kaiser Traditional Part-time & Retiree
- ☐ ODS Traditional
- ☐ Willamette

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 F	Gender M	Prior PEBB Member Y	Prior PEBB Member N	Enroll In Med	Enroll In Dental
						☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐

SECTION D – DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

D.1 Dependent certification – see Section D 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 Medicare Information – see Section D 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

"PEBB Use Only"

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