PEBB Medical And Dental Enrollment Form
Self Pay Participants
2009 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: Select one.
  B.2: Dental: Not all participants are eligible for dental.
  Note: Blind Business Enterprise Participants are eligible for medical plan enrollment **only.**
  .

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 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, 1-800-556-3137 or 503-765-3581 (Portland) or the PEBB web site at www.oregon.gov/DAS/PEBB in the Summary Plan Document.

SECTION D – DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

- Check the appropriate box.
  D.1: You must certify that your dependent children between 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 enrollment type 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

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Medical And Dental Enrollment Form
Self Pay Participants
2009 Plan Year

SECTION A - PARTICIPANT INFORMATION

☐ New Participant—provide the date you became eligibile:

☐ OLCC Agent ☐ Post Docs/J1 Visa ☐ Blind Business Enterprise ☐ Open Enrollment

☐ Foster Parent – you must attach a copy of the Foster Parent Certificate

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

E-MAIL

SECTION B - MEDICAL AND DENTAL PLAN ELECTIONS (Must have Medical Coverage to enroll in a Dental Plan):

B-1 Medical (select one):

☐ No Coverage
☐ Kaiser HMO
☐ Kaiser Added Choice
☐ Providence Choice PPO
☐ Regence BCBSO PPO

B-2 Dental (select one): Not all participants are eligible for dental. Please see instructions.

☐ No Coverage
☐ Kaiser Traditional Full Time
☐ Willamette
☐ ODS Preferred Option
☐ ODS Traditional

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	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 instructions. Detailed eligibity information is availabe at www.oregon.gov/DAS/PEBB in the Summary Plan Document

☐ I certify that all my dependent children, 19 to 24 meet the eligiblity 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. 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 _____ Date _____

"PEBB Use Only"

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