



Complete this form to make changes in your medical and dental insurance coverage when you experience a qualified status change (QSC). This form replaces all previous enrollment forms. Please fill out only one form per QSC event.

- **You must submit this completed form within 60 days of and consistent with the QSC.**

Section A – Subscriber Information

- Complete all items in this section.
- If you are updating your address information, check the New Address box.

Section B – Qualified Status Change (QSC) Information

The requested change must be because of and consistent with the QSC. Please refer to your PEBB benefit booklet for guidelines.

B.1 Change Requested

- Select the change requested. Submit only one change request per form.
- If you are opting out of the medical plan because you gained other group coverage, you must provide the other group coverage information in Section D.
- If you are adding a dependent to coverage, you must complete Section C. List all eligible dependents you want to cover including the new dependent.

B.2 QSC Date and QSC Event

- Enter the QSC ate. This is the date the event occurred.
- Check the QSC Event.
- If you are:
 - Enrolling a domestic partner or a partner's children for the first time, attach a signed Affidavit of Domestic Partnership.
 - Enrolling a newly eligible child who is not your or your spouse's or domestic partner's biological or adopted child, attach a signed Affidavit of Dependency and documentation of the adoption agreement (if applicable).
 - Removing a dependent from coverage, you must provide the name, ID number and an address.
 - Terminating a domestic partnership, attach a signed Termination of Domestic Partnership form.

Section C – Dependent Information and Coverage Selection

- List **all** eligible dependents you want to cover, along with their ID numbers and dates of birth, and check the box that indicates their relationship to you. **Dependents not listed will not be covered.**
- If you are enrolling a dependent who was previously covered by a PEBB plan, check the Prior PEBB Member box to avoid duplicate records and coordinate benefits.
- Check plan selections for each dependent.

Section D – Coordination of Benefits

- Check the appropriate boxes in this section.
- If you are eligible to and have selected Medical Opt Out under the Change Requested (Section B.1), provide the other medical group insurance coverage information in this section.
- If you have additional group medical, dental and/or pharmacy insurance coverage, provide that information in this section.

Section E – Employee or Subscriber Signature and Authorization

- Read this section carefully. Sign and date the form. Make a copy for your records, and submit the completed form as follows:
 - Active Employees and Semi-Independent Agency Employees to: your agency payroll or university benefits office.
 - COBRA and other self-pay participants to: BenefitsHelp Solutions (BHS)
PO Box 67240
Portland, OR 97268-1240



A	SUBSCRIBER INFORMATION					
	LAST NAME	FIRST	MI	ID NUMBER (SSN, University ID, Benefit Number)		
	DATE OF BIRTH (MM-DD-YYYY)			GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		
	RESIDENCE ADDRESS <input type="checkbox"/> New Address			CITY	STATE	ZIP
				COUNTY		HOME PHONE
MAILING ADDRESS (if different from above) <input type="checkbox"/> New Address			AGENCY		WORK PHONE	

B	QUALIFIED STATUS CHANGE (QSC) INFORMATION		
	B.1 Change Requested (Select one per form)		
	<input type="checkbox"/> Add a dependent <i>List all eligible dependents you wish to cover in Section C. Make sure you include your new dependent.</i>	<input type="checkbox"/> Remove a dependent Name, ID # and Address _____ _____ _____ Attach sheet for additional dependents.	<input type="checkbox"/> Change Plans <input type="checkbox"/> Medical <input type="checkbox"/> Dental New Plan: _____ <i>For Medical Opt Out coverage, complete Section D</i>
B.2 QSC Date and QSC Event			
QSC Date (when did the change occur? e.g.: marriage or birth) (mm-dd-yyyy): _____ QSC Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce (becomes final) <input type="checkbox"/> Gain other group coverage. <input type="checkbox"/> Met domestic partner eligibility <input type="checkbox"/> Termination of domestic partnership <input type="checkbox"/> Involuntary loss of other group coverage. <input type="checkbox"/> Birth <input type="checkbox"/> Death of a dependent <input type="checkbox"/> Other (describe): _____ <input type="checkbox"/> Adoption or placement for adoption <input type="checkbox"/> Dependent ceases to meet eligibility. <input type="checkbox"/> Dependent(s) gains eligibility due to: _____ <input type="checkbox"/> Employment status change (describe): _____			

C	DEPENDENT INFORMATION AND COVERAGE SELECTION																																																																			
	List all eligible dependents you wish to cover and check the plans for coverage. If covering a domestic partner, partner's children, or dependent by affidavit for the first time, a completed affidavit must be attached or on file. Dependents not listed will not be covered.																																																																			
	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																																																																			
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:20%;">Dependent's Last Name</th> <th style="width:10%;">First</th> <th style="width:5%;">MI</th> <th style="width:15%;">ID Number (SSN, Benefit Number)</th> <th style="width:10%;">DOB (mm-dd-yyyy)</th> <th style="width:10%;">Relationship to you (See key above)</th> <th style="width:5%;">Gender</th> <th style="width:5%;">Prior PEBB Member</th> <th colspan="2" style="width:20%;">Plan</th> </tr> <tr> <th colspan="7"></th> <th>Y / N</th> <th>Medical</th> <th>Dental</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td>F / M</td><td>Y / N</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td>F / M</td><td>Y / N</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td>F / M</td><td>Y / N</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td>F / M</td><td>Y / N</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </tbody> </table>									Dependent's Last Name	First	MI	ID Number (SSN, Benefit Number)	DOB (mm-dd-yyyy)	Relationship to you (See key above)	Gender	Prior PEBB Member	Plan									Y / N	Medical	Dental							F / M	Y / N	<input type="checkbox"/>	<input type="checkbox"/>							F / M	Y / N	<input type="checkbox"/>	<input type="checkbox"/>							F / M	Y / N	<input type="checkbox"/>	<input type="checkbox"/>							F / M	Y / N	<input type="checkbox"/>	<input type="checkbox"/>
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D	COORDINATION OF BENEFITS INFORMATION		
	Are you or any of your dependents covered through another PEBB <input type="checkbox"/> or another group <input type="checkbox"/> plan? If yes, complete the following information:		
	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy		
	Carrier:	Group No.:	
	Policy No.:	Employer:	
Subscriber's Name:			
Effective Date: (mm-dd-yyyy)	Are you or your dependents covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Who is covered?		

E	EMPLOYEE OR SUBSCRIBER SIGNATURE AND AUTHORIZATION
	I acknowledge and understand PEBB health insurance carriers may request or disclose health information about me or my enrolled dependents from time to time for the purpose of facilitating healthcare payment or treatment; or for the purpose of business operations necessary to administer healthcare benefits; or as required or allowed by law. Health information may be related to treatment or services performed by a health care practitioner, dentist, pharmacist, hospital, or other institution providing healthcare, or an insurance carrier or group plan. I understand the benefit elections I have made on this form are in effect, as long as eligibility requirements are met, until I elect to change them subject to the provisions of each plan. I have read the benefit materials and understand the limitations and qualifications of the PEBB benefit program. I authorize premium payments to be deducted from my pay, unless I self-pay premiums. If I self-pay premiums, I agree to submit monthly payments by the date specified, or my coverage will be terminated and cannot be reinstated until the next open enrollment period. This authorization will remain valid until I sign and submit a new Medical/Dental Update Form or update within the provisions of the benefit program. I certify that all information provided by me on this form is accurate and correct, allowing for my participation.
Employee or Subscriber Signature _____	Date _____

*****OFFICIAL USE ONLY*****

PROCESSED BY:	PDB INPUT:	DATE:
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