

**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 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.



Medical and Dental Enrollment Form

Active Employee

2009 Plan Year

SECTION A - EMPLOYEE INFORMATION

<input type="checkbox"/> NEW EMPLOYEE		HIRE DATE:		<input type="checkbox"/> OPEN ENROLLMENT	
LAST		FIRST		MI	ID NUMBER (SSN, University, Benefit)
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	
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):
<input type="checkbox"/> Kaiser HMO <input type="checkbox"/> Kaiser Added Choice <input type="checkbox"/> Providence Choice PPO <input type="checkbox"/> Regence BCBSO PPO	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 	<input type="checkbox"/> Opt Out – You must have other group coverage to be eligible. See Section D for instructions. <input type="checkbox"/> 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.	<input type="checkbox"/> Kaiser Traditional Full-Time <input type="checkbox"/> ODS Preferred Option <input type="checkbox"/> ODS Traditional <input type="checkbox"/> Willamette <input type="checkbox"/> ODS Part-time & Retiree <input type="checkbox"/> 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		Prior PEBB Member		Enroll In	
						F	M	Y	N	Med	Dental
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 eligibility 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
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Subscriber's Name	Employer	Effective Date
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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):