



# Enrollment Form

## Active Employees

- Office Use Only -

Approved by \_\_\_\_\_ Date \_\_\_\_\_

Effective Date \_\_\_\_\_

See the Summary Plan Description for more information: [www.oregon.gov/DAS/PEBB/SPD.shtml](http://www.oregon.gov/DAS/PEBB/SPD.shtml)

**Submit completed form to your agency payroll or university benefits office**

### 1. I am Enrolling as a

Newly Eligible Employee

2009 Newly Eligible Employee enrolling for 2010

### 2. Contact Information

PEBB Benefit Number (P#####), Employee ID, University ID

|           |            |    |          |   |
|-----------|------------|----|----------|---|
| Last Name | First Name | MI | Agency # | Gender<br><input type="checkbox"/> F <input type="checkbox"/> M |
|-----------|------------|----|----------|---|

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

|                                      |   |                     |      |                                |     |        |
|--------------------------------------|---|---------------------|------|--------------------------------|-----|--------|
| Contact Address                      | <input type="checkbox"/> Check if New Address | Apt #               | City | State                          | Zip | County |
| Residence Zip Code                   | Work Zip Code                                 | Work E-mail         |      | Personal E-mail (optional)     |     |        |
| Date of Birth<br>_ _ / _ _ / _ _ _ _ |   | Work Phone<br>( ) - |      | Home Phone (optional)<br>( ) - |     |        |

### 3. Dependent Information

Attach separate sheet if necessary

**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\* (must attach Affidavit\* of Dependency)

| Last Name | First Name | MI | Birth Date<br>(mm/dd/yyyy) | Relationship | Gender                   |                          | Enroll                   |                          |
|-----------|------------|----|----------------------------|--------------|--------------------------|--------------------------|--------------------------|--------------------------|
|           |            |    |                            |              | M                        | F                        | Med                      | Den                      |
|           |            |    |                            |              | <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"/> |

### Dependent Certification ages 19 up to 24

I certify that dependents age 19 up to 24 listed here are eligible for coverage under PEBB rules.

Certification applies to (Check one).

Current Plan Year (newly eligible)

Coming Plan Year (open enrollment)

### Type of Domestic Partnership (if applicable)

By PEBB Affidavit\*

By Registered Certificate (no copy required)

**\*Affidavit Information**

If you are adding a dependent or domestic partner by affidavit, you must submit the affidavit to your payroll/benefit office within five business days of this enrollment, or the individual's coverage will be terminated back to the effective date.

## 4. Medical and Dental Plans

Choose your benefit election and plan. Only part-time employees may enroll in a part-time or full-time plan.

I elect to (select one):

- Enroll in Medical and Dental plans  
 Decline PEBB Benefits

| Medical Plan<br>(select one)                 | Full-time<br>Plan        | Part-time<br>Plan        | Dental Plan<br>(select one) | Full-time<br>Plan        | Part-time<br>Plan        |
|--|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| PEBB Statewide Plan                          | <input type="checkbox"/> | <input type="checkbox"/> | Kaiser Permanente           | <input type="checkbox"/> | <input type="checkbox"/> |
| Kaiser Permanente                            | <input type="checkbox"/> | <input type="checkbox"/> | ODS Traditional             | <input type="checkbox"/> | <input type="checkbox"/> |
| Providence Choice                            | <input type="checkbox"/> | <input type="checkbox"/> | ODS Preferred               | <input type="checkbox"/> |                          |
| Medical Opt Out<br>(Must fill out Section 5) | <input type="checkbox"/> |                          | Willamette Dental           | <input type="checkbox"/> |                          |

## 5. Other Group Coverage

Are you or any of your dependents covered through another group plan?  Yes  No

If yes, please complete the following information.

**Medical Opt Out:** You must provide proof of coverage (e.g. copy of medical card or employer statement of medical coverage) to your agency within five business days of this enrollment and complete the information below.

|  |   |         |               |                                       |
|--|---|---------|---------------|---------------------------------------|
| <b>Plan Type:</b>                      | Plan  | Carrier | Policy Number | Group Number                          |
|  | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental |         |               |                                       |
| Principal Enrollee in Other Group Plan |   |         | Employer      | Effective Date<br>_ _ / _ _ / _ _ _ _ |

## 6. Medicare Coverage

I am covered by Medicare     A dependent is covered by Medicare     Not Applicable

**Complete the following sections only to enroll or to change current elections.**

## 7. Optional Life Insurance

|   |                    |   |
|---|--------------------|---|
| <b>Employee Optional Life Insurance</b><br>(\$20,000 increments, maximum \$600,000) |                    | <b>Newly Eligible ONLY:</b> <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$40,000<br>Guarantee Issue (medical history is <b>not</b> required) |
| <b>Enroll*</b>  | <b>Change*</b>     | <b>Cancel Coverage</b>  |
| Total Coverage: \$  | Total Coverage: \$ | <input type="checkbox"/>  |

|   |                                    |   |
|---|------------------------------------|---|
| <b>Spouse or Domestic Partner Optional Life Insurance</b><br>(\$20,000 increments, maximum \$400,000) |                                    | <b>Newly Eligible ONLY:</b> <input type="checkbox"/> \$20,000<br>Guarantee Issue (medical history is <b>not</b> required) |
| Name  | Spouse<br><input type="checkbox"/> | Domestic Partner<br><input type="checkbox"/>  |
|   |                                    | Date of Birth<br>_ _ / _ _ / _ _ _ _  |
| <b>Enroll*</b>  | <b>Change*</b>                     | <b>Cancel Coverage</b>  |
| Total Coverage: \$  | Total Coverage: \$                 | <input type="checkbox"/>  |

**\*Any coverage amount that is not guarantee issue requires a medical history statement.**

|  |  |
|--|--|
| <b>Dependent Life Insurance</b><br>\$5,000 of coverage for each eligible dependent (including spouse or domestic partner). Medical history is <b>not</b> required. |  |
| <input type="checkbox"/> Enroll for Coverage   | <input type="checkbox"/> Cancel Coverage |

## 8. Accidental Death & Dismemberment (AD&D)

|  |   |
|--|---|
| <input type="checkbox"/> Enroll for Employee Only Coverage           | <input type="checkbox"/> Change Coverage Amount   |
| <input type="checkbox"/> Enroll for Employee and Dependents Coverage | <input type="checkbox"/> Cancel Coverage          |
| <b>Total Amount</b>  | \$ _____ (\$50,000 increments, maximum \$500,000) |

## 9. Beneficiary Designation

Primary beneficiaries are first in line for distribution; contingent beneficiaries are next.

### I elect:

- The **Standard Order of Survivorship** as established by Oregon law (no beneficiaries listed)
- To designate the following beneficiary(s)  
(Attach separate sheet if necessary)

| Name | Address | City | State | Zip | Relationship | Primary                  | Contingent               | Percentage |
|------|---------|------|-------|-----|--------------|--------------------------|--------------------------|------------|
|      |         |      |       |     |              | <input type="checkbox"/> | <input type="checkbox"/> | %          |
|      |         |      |       |     |              | <input type="checkbox"/> | <input type="checkbox"/> | %          |
|      |         |      |       |     |              | <input type="checkbox"/> | <input type="checkbox"/> | %          |

## 10. Disability Insurance (replace a portion of salary when employee is eligible for the benefit)

|                              |  |  |
|------------------------------|--|--|
| <b>Short Term Disability</b> | <input type="checkbox"/> Enroll for Coverage<br><input type="checkbox"/> Cancel Coverage   |  |
| <b>Long Term Disability</b>  | <input type="checkbox"/> Enroll for Coverage<br><input type="checkbox"/> Change Coverage<br><input type="checkbox"/> Cancel Coverage | <b>Waiting Periods and Coverage Level (select one)</b>   |
|                              |  | <input type="checkbox"/> 90 days – 60% <input type="checkbox"/> 180 days – 60%<br><input type="checkbox"/> 90 days – 66 2/3% <input type="checkbox"/> 180 days – 66 2/3% |

## 11. Employee 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.

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

If you **DO NOT** want premiums deducted on a before-tax basis, **initial here** \_\_\_\_\_.

**Submit completed form to your agency payroll or university benefits office.**

**Keep a copy of all benefit documents for your records.**