

Life and Disability Insurance Update Form

Midyear Change Request

Instructions

Complete this form to make changes to your life, disability and/or accidental death and dismemberment (AD&D) coverage because of and consistent with a qualified status change (QSC) event. *The effective date for any approved change is the first of the month following either the date of the QSC or the receipt date of the form by the agency, whichever is later.* Submit one form per QSC.

- If you are making only a name and/or address change, complete Sections A and D only.
- To change your beneficiary designation you may do so online at <https://pebb.benefits.oregon.gov/members>, or by completing the PEBB Designation of Beneficiary form. Submit the completed form to your agency payroll, personnel or benefits office.
- **To make a change to your benefits because of a QSC, you must submit this completed form within 60 days of and consistent with the QSC.**
- If selecting insurance for a domestic partner or a partner's children, attach a signed Affidavit of Domestic Partnership.
- If terminating a domestic partnership, attach a signed Termination of Domestic Partnership form.
- If selecting insurance for a newly eligible child who is not your, your spouse's or your domestic partner's biological or adopted child, attach a signed Affidavit of Dependency and documentation of the adoption agreement (if applicable).

SECTION A – EMPLOYEE OR SUBSCRIBER INFORMATION

- Complete all items in this section.
- If making a change to your address, check the New Address box.

SECTION B – QUALIFIED STATUS CHANGE INFORMATION

The requested change must be because of and consistent with the QSC. ***Please refer to your PEBB benefits handbook for guidelines and effective date information.***

B.1 Enter the date the QSC occurred, such as the date of marriage, date of birth or the final date of divorce.

B.2 Select the QSC event that applies to your situation.

SECTION C – REQUESTED ENROLLMENT OR CHANGES

C.1 LIFE INSURANCE: Complete this section if you wish to enroll in or change your current life insurance coverage. This includes the Accidental Death and Dismemberment coverage.

- **Dependent Life Coverage.** Coverage amount is \$5,000 for all eligible dependents. You do not need to enroll your eligible dependents in any other PEBB plans for them to be eligible for this coverage.
 - **Optional Life for Employee and Spouse or Domestic Partner Coverage.** The amount you choose must be in increments of \$20,000, up to a maximum of \$400,000 per individual.
 - **Newly Eligible** – When you enroll within the first 60 days of your eligibility or hire date you and your spouse or domestic partner qualify for \$20,000 of ***Guarantee Issue*** optional life coverage. This means that you may enroll for \$20,000 of coverage per individual and you do not need to complete the Medical History Statement.
 - **Newly Eligible** – When you enroll within the first 60 days of your eligibility or hire date and **you want more than \$20,000** optional life coverage for you, your spouse, or domestic partner you must complete a Medical History statement.
 - **Accidental Death and Dismemberment (AD&D) Coverage.** Check the appropriate boxes in the Coverage Tier and Coverage Choice sections.
- C.2 DISABILITY INSURANCE:** Complete this section if you wish to enroll in or change your current disability coverage.
- To cancel either disability coverage, check the **Cancel** box under **Coverage Type**.
 - If you are enrolling for Long Term Disability coverage, check a box under **Waiting Period - Coverage Level**.
 - To change your current Long Term Disability coverage level, check the **Change in Coverage** box under **Coverage Type**. Also, select a new **Waiting Period – Coverage Level**.

SECTION D – EMPLOYEE SIGNATURE AND AUTHORIZATION

- Read this section carefully.
- Sign and date the form.
- Make a copy for your records, and **submit the completed form to your agency payroll, personnel or benefits office.**

Send the Medical History Statement directly to The Standard Insurance Company at the address shown on the statement.



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Read the instructions before you complete and submit this form. All previous coverage will continue unless you change the level of coverage or cancel the coverage.

SECTION A - EMPLOYEE INFORMATION

Change of: Status Name Address

LAST NAME	FIRST NAME	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	
EMAIL ADDRESS				

SECTION B - QUALIFIED STATUS CHANGE (QSC) INFORMATION

B.1 QSC Date: _____ This is the date the QSC occurred (i.e., marriage, birth, final date of divorce, etc)

B.2 Select the QSC that allows you to enroll in or make changes to life and/or disability coverage. The requested change must be because of and consistent with this QSC.

Check one:

- | | |
|--|---|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Death of a dependent |
| <input type="checkbox"/> Met domestic partner eligibility
(Attach Affidavit of Domestic Partnership) | <input type="checkbox"/> Termination of domestic partnership
(Attach Termination of Domestic Partnership form) |
| <input type="checkbox"/> Divorce (only if final), Annulment or Legal Separation | <input type="checkbox"/> Dependent ceases to meet eligibility |
| <input type="checkbox"/> Birth | <input type="checkbox"/> Employment status change (describe):
_____ |
| <input type="checkbox"/> Adoption or placement for adoption | <input type="checkbox"/> Other (describe):
_____ |
| <input type="checkbox"/> Dependent(s) gains eligibility
(Attach Affidavit of Dependency, if applicable) | |

SECTION C - REQUESTED ENROLLMENT OR CHANGES

C.1 LIFE INSURANCE

Dependent Life (\$5,000 coverage) New coverage Cancel

Optional Employee Life (\$20,000 increments to \$400,000)

Designate beneficiaries for this benefit online or by completing the PEBB Designation of Beneficiary form.

- | | |
|--|--|
| <input type="checkbox"/> New coverage amount \$ _____ * | <input type="checkbox"/> Medical history statement submitted |
| <input type="checkbox"/> Change coverage from \$ _____ to \$ _____ TOTAL *
(include existing coverage) | <input type="checkbox"/> Medical history statement submitted |
| <input type="checkbox"/> Cancel | |

***Medical history statement may be required. See form instructions**

Optional Spouse or Partner Life (\$20,000 increments to \$400,000)

Spouse or Partner's Name: _____ ID# (SSN, University ID, Benefit Number): _____ Date of Birth: _____

- | | |
|--|--|
| <input type="checkbox"/> New coverage amount \$ _____ * | <input type="checkbox"/> Medical history statement submitted |
| <input type="checkbox"/> Change coverage from \$ _____ to \$ _____ TOTAL*
(include existing coverage) | <input type="checkbox"/> Medical history statement submitted |
| <input type="checkbox"/> Cancel | |

***Medical history statement may be required. See form instructions**

Accidental Death and Dismemberment (AD&D) (\$50,000 increments to \$500,000)

Designate beneficiaries for this benefit online or by completing the PEBB Designation of Beneficiary form.

Coverage Tier:

- Employee only
- Employee and dependents

Coverage Choice:

- New coverage (indicate amount) \$ _____
- Change coverage amount from \$ _____ to \$ _____
- Cancel

C.2 DISABILITY INSURANCE

Short Term Disability

Coverage Type:

- New coverage
- Cancel

Long Term Disability

Coverage Type:

- New coverage
- Change in coverage
- Cancel

Waiting Period - Coverage Level

- 90 day - 60%
- 90 day - 66 2/3%
- 180 day - 60%
- 180 day - 66 2/3%

SECTION D - EMPLOYEE SIGNATURE AND AUTHORIZATION

I acknowledge and understand PEBB insurance carriers may request or disclose information about me or my enrolled dependents from time to time for the purpose of facilitating insurance payments; or for the purpose of business operations necessary to administer employee benefits; or as required or allowed by law. 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. This authorization will remain valid until I sign and submit a new Life and Disability Enrollment or Update Form or within the provisions of the benefit program.

Employee Signature

Date

"PEBB Use Only"

Approved by (initials):

Date:

Approved change effective date:

PDB updated by (initials):