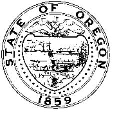
PUBLIC EMPLOYEES'
PEBB
BENEFIT BOARD

Public Employees' Benefit Board (PEBB) Medical and Dental Insurance Update Form Instructions



- Complete this form to make changes in your medical and dental insurance coverage when you have a qualified family status change.
- You must submit the completed form within 60 days following the status change.
- If enrolling a domestic partner, attach a signed Affidavit of Domestic Partnership. If terminating a domestic partnership, attach a signed Termination of Domestic Partnership Form, or
- If you are enrolling a newly eligible child who is not your or your spouse's natural or legally adopted child, attach a signed Affidavit of Dependency and/or copies of other legal or court documents indicating dates you became responsible for financial and other medical care of the child.

SECTION A–EMPLOYEE/SUBSCRIBER INFORMATION

You must complete Section A when making any changes to your medical or dental coverage. If you are making only a name or address change, complete only Section A.

SECTION B–STATUS CHANGES

You must complete sections B and C when requesting a change due to a qualified family status change.

- Write the date of the change on the "Status change date" line.
- The requested changes must be because of and consistent with the qualified family status change.
- PLEASE REFER TO YOUR PEBB ELIGIBILITY HANDBOOK FOR GUIDELINES.

SECTION C–ELIGIBLE INDIVIDUALS INFORMATION

- **You must list all individuals you want continued on the medical or dental coverage** unless you are making only a name or address change. This form replaces all previous enrollment forms.
- Check the box that indicates whether you are requesting medical, dental, or both coverage options for each individual you are continuing on coverage.
- If your medical plan is an HMO, list the Primary Care Physician (PCP) for yourself and each insured individual.

SECTION D–COORDINATION OF BENEFITS INFORMATION

Complete this section if you or any insured individuals have other coverage OR if you are opting out of PEBB medical coverage.

- Check the appropriate box for the insured individuals who have other coverage.
- For insured individuals with different coverage information, include another page with the necessary information.

SECTION E–EMPLOYEE/SUBSCRIBER SIGNATURE

Active employees sign, date, and return the form to your personnel or payroll office. Retiree, COBRA, Self-pay and Semi- Independent participants return the form to Best Choice Administrators, PO Box 67240, Portland, OR 97268-1240.

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

PUBLIC EMPLOYEES' BENEFIT BOARD (PEBB) **MEDICAL AND DENTAL** UPDATE FORM

A EMPLOYEE/SUBSCRIBER INFORMATION

☐ Status Change ☐ Name Change ☐ Address Change

☐ Active Employee ☐ Retired ☐ COBRA ☐ Semi-Independent/Self Pay

Last Name ______ First ______ M. I. ______

If Name Change - Previous Name ______ Home Ph. (____) _____ - ________

Address ______ New Address ☐

City ______ County ______ State ______ Zip ______

Social Security Number ______ - ______ - ______ Date of Birth ______ ☐ Male ☐ Female

Agency ______ Agency Number ______ Work Ph. ( ) _____ - _____ Ext. _____

Indicate your current coverage. OR: If requesting a plan change, indicate new carrier(s) selected.

MEDICAL/Carrier and plan name ______ GROUP # ______ ☐ Current ☐ New

DENTAL/Carrier and plan name ______ GROUP # ______ ☐ Current ☐ New

Office Use Only

Agency No. ______

1. ODS dental, subject to wait period? Yes No

2. Last day of paid time ______

3. Coverage End Date ______

4. Date R'td to work ______

5. DP? Yes No

Medical Plan Code: ______

Ded. Start ______

Eff. Date ______

Plan Code ______

Ded. Stop ______

Dental Plan Code: ______

Ded. Start ______

Eff. Date ______

Plan Code ______

Ded. Stop ______

PEBB Approval ______

B STATUS CHANGES ☐ **Medical** ☐ **Dental**

Status change date ______

Was prior coverage continued on self-pay basis through COBRA?

Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

☐ Involuntary loss of other group coverage, indicate:

Insurance co. name ______

Date of loss ______

☐ Opt Out of Medical Coverage

(Complete Coordination of Benefits Information Section D)

☐ Add or ☐ Delete insured individual

☐ Change carriers due to moving out of HMO or dental service area

☐ Met domestic partner eligibility

☐ Marriage ☐ Divorce (Use Final Date)

☐ Birth ☐ Adoption ☐ Death of Insured Individual

☐ Other - Describe: ______

______

______

Individual losing status (list name, address and SSN):

______

______

______

C LIST ALL ELIGIBLE INDIVIDUALS YOU WISH TO INSURE. **List primary care physician for each if participating in HMO.**

Name	M/F	Relationship	Date of Birth	SS Number	Medical	Dental	HMO Primary Care Physician
– LIST ELIGIBLE INDIVIDUALS BELOW –					EMPLOYEE/SUBSCRIBER		
LAST NAME FIRST M.I.							
			- -	- -	☐	☐	
Spouse			- -	- -	☐	☐	
Domestic Partner			- -	- -	☐	☐	
Child			- -	- -	☐	☐	
Child			- -	- -	☐	☐	
Child			- -	- -	☐	☐	
Child							

D COORDINATION OF BENEFITS INFORMATION

If ☐ you, ☐ your spouse, ☐ your domestic partner, or ☐ your dependent children are covered under another group health plan, complete the following:

______ Insurance Company ______ Policy Number/SSN ______ Name of individual with other coverage

Other coverage provided through ☐ PEBB ☐ Other ______ (Employer Name)

Are ☐ you or ☐ your insured individuals eligible for Medicare? ☐ Yes ☐ No If yes, attach a copy of the Medicare Eligibility Card.

I understand the elections I have made are in effect, as long as eligibility requirements are met, until I elect to change them subject to the provisions of each plan. Benefit costs in excess of my state contribution will be taken out of my pay by payroll deduction. I have read the benefit materials and understand the limitations and qualifications of the PEBB Benefits program.

I authorize any medical care institution, medical provider, or dentist to furnish my medical or dental carrier with any information related to the physical or mental condition, medical history, or medical/dental treatment of insured individuals when administering claims under my policy. This authorization will remain valid until a new document has been signed and submitted.

E EMPLOYEE/SUBSCRIBER SIGNATURE ______ Date ______

ACTIVE EMPLOYEES RETURN COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE. RETIREE, COBRA, SELF-PAY AND SEMI-INDEPENDENT PARTICIPANTS RETURN FORM TO BEST CHOICE ADMINISTRATORS, PO BOX 67240, PORTLAND, OR 97268-1240

F-U-MD-E 2/02 AGENCY - White MEDICAL CARRIER - Blue DENTAL CARRIER - Pink EMPLOYEE - Yellow