

**Medical And Dental Enrollment Form**  
**Active Employee**  
**2007 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 A – EMPLOYEE INFORMATION**

- Complete each item in this section.
- If you are a new employee, provide your date of hire.
- If you are completing this form during Open Enrollment, check the appropriate box.

**SECTION B – MEDICAL AND DENTAL PLAN ELECTIONS**

Check the box of the plan(s) you are selecting.

B-1: Only eligible part-time employees may choose a part-time plan.

- To opt out of enrollment in a PEBB medical plan, you must complete Section D.
- To decline enrollment in all PEBB plans, you waive your rights to the monthly benefit amount.

B-2: Each employee must enroll in at least “employee only” dental to participate in the PEBB benefits program.

**SECTION C – DEPENDENT INFORMATION AND PLAN SELECTION**

- List all eligible dependents. **Dependents not listed will not be covered.**
- If you are enrolling a domestic partner, a domestic partner's child or a child by affidavit, attach a completed Affidavit of Domestic Partnership or Affidavit of Dependency. Contact your agency payroll/personnel office, university benefits office or PEBB if you need a form or further information. Forms are also available at <http://oregon.gov/das/pebb>.
- If you are enrolling a dependent who was previously covered by PEBB, check the Prior PEBB Member box to avoid creating duplicate records and to coordinate benefits.
- Check plan selections for each dependent, medical only, dental only or both.

**SECTION D – COORDINATION OF BENEFITS INFORMATION**

- Complete this section if you or your dependents have other coverage.
- Provide all requested information.

**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.



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**SECTION A - EMPLOYEE INFORMATION**

<input type="checkbox"/> NEW EMPLOYEE		HIRE DATE :		<input type="checkbox"/> OPEN ENROLLMENT	
LAST		FIRST		MI	ID NUMBER (SSN, OUS#, 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>B-1 Medical (select one):</b>	Full-Time Plan	Part-Time Plan	<b>Alternative Choice:</b> <input type="checkbox"/> Opt Out - You must have other group coverage to be eligible and complete Section D. <input type="checkbox"/> Decline - You waive rights to the employer contribution and enrollment in all PEBB programs. You will receive no portion of the state contribution as cash.	<b>B-2 Dental (select one):</b>
<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"/> Samaritan Select 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"/> <input type="checkbox"/>		<input type="checkbox"/> Kaiser Permanente <input type="checkbox"/> ODS Preferred Option <input type="checkbox"/> ODS Traditional <input type="checkbox"/> ODS Part-time and Retiree <input type="checkbox"/> Willamette

**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. **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 (SSN, OUS ID or Benefit #)	Date Of Birth (mm-dd-yyyy)	Relationship (See Key above)	Gender		Prior PEBB Member		Plan	
						F	M	Y	N	Medical	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"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

