

Medical And Dental Update Form Midyear Change Request Instructions

Complete this form to make changes to your medical and/or dental insurance coverage because of and consistent with a qualified status change event (QSC). *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 make a change to your benefits because of a QSC, you must submit this completed form within 60 days because of and consistent with the QSC.**
- If enrolling 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 enrolling a newly eligible child who is not your, your spouse's or 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 change requested.

B.3 Select the QSC:

- If adding a new dependent, please list the requested information for each person. If you are enrolling a domestic partner, a partner's child or a child by affidavit for the first time, attach a completed Affidavit of Domestic Partnership or Affidavit of Dependency. Contact your agency payroll, personnel, benefits office or PEBB if you need an Affidavit. Domestic partner coverage information and forms are also available on the PEBB Web site at: <http://oregon.gov/das/pebb>. Attach an extra sheet to list more dependents if necessary.
- 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.
- Select medical, dental or both for each new dependent.

B.4 If removing a dependent, please include the person's name and address for the purpose of the COBRA notice.

B.5 Select the QSC:

- If you are opting out of medical coverage because you gained other group coverage—complete the other group coverage information in Section C.
- Changes to medical or dental plans are allowed only if you move out of the plan's service area, because of and consistent with a change in employment status or if you receive a National Medical Support Notice (NMSN).

SECTION C – COORDINATION OF BENEFITS

- Complete this section if you or your dependents have other coverage.
- Provide all requested information.
- If you elected to opt out under Section B.5, provide the other group medical coverage information in this section.
- The other group medical coverage must meet the PEBB definition.

SECTION D – EMPLOYEE OR SUBSCRIBER SIGNATURE AND AUTHORIZATION

- Read this section carefully.
- Sign and date the form.
- Make a copy for your records, and submit the completed form as follows:
 - Self-pay participants (including COBRA), send to BHS, PO 67240, Portland, OR 97268-1240.
 - Active employees, submit to your payroll or university benefits office.

B.5 Select the QSC that allows you to *change your plans* outside of open enrollment (one QSC per form):

- OPT OUT OF PEBB MEDICAL PLANS** due to gaining other group medical coverage. Must complete Section C.
- DECLINE ALL BENEFITS** – You waive rights to the employer contribution and enrollment in all PEBB programs. You will receive no portion of the state contribution as cash.

- CHANGE MEDICAL OR DENTAL PLANS** due to:
- National Medical Support Notice (NMSN)
 - Employment status change such as Full Time to Part Time
 - Move out of the plan's service area
- ENROLL IN PEBB MEDICAL PLANS** from opt out due to loss of other group medical coverage

<p>Medical (select one):</p> <p><input type="checkbox"/> Opt out</p> <p><input type="checkbox"/> Kaiser HMO</p> <p><input type="checkbox"/> Kaiser Added Choice</p> <p><input type="checkbox"/> Providence Choice PPO</p> <p><input type="checkbox"/> Regence BCBSO PPO</p> <p><input type="checkbox"/> Samaritan Select PPO</p>	<p>Full-Time Plan</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p>Part-Time Plan</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p>Dental (select one):</p> <p><input type="checkbox"/> Kaiser Permanente</p> <p><input type="checkbox"/> ODS Preferred Option</p> <p><input type="checkbox"/> ODS Traditional</p> <p><input type="checkbox"/> ODS Part-time and Retiree</p> <p><input type="checkbox"/> Willamette</p>
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SECTION C - COORDINATION OF BENEFITS

Are any of these new dependents covered through another PEBB or another group plan? If yes, complete the following information:

Medical Dental Pharmacy

Carrier	Group No
Policy No	Employer
Subscriber's Name	
Effective Date (mm-dd-yyyy)	Does Medicare cover any of these newly eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No
Who is covered?	

SECTION D - EMPLOYEE/SUBSCRIBER SIGNATURE AND AUTHORIZATION

I acknowledge and understand PEBB health insurance carriers may request or disclose health information about me or my enrolled dependents from time to time for facilitating healthcare payment or treatment; or for the purpose of business operations necessary to administer healthcare benefits; or as required or allowed by law. Health 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, or 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, unless I self-pay premiums. If I self-pay premiums, I agree to submit monthly payments by the date specified, or my coverage will be terminated and cannot be reinstated until the next open enrollment period. This authorization will remain valid until I sign and submit a new or updated Medical/Dental Enrollment form within the provisions of this benefit program.

_____ Date _____

Employee/Subscriber Signature

PEBB Use Only R08/06

Approved By PEBB (initials): Date: Effective date: PDB updated by (initials):