

**PEBB Life And Disability Update Form  
Midyear Change Request  
Instructions  
[www.oregon.gov/DAS/PEBB](http://www.oregon.gov/DAS/PEBB)**

Complete this form to make midyear changes to your Life, Disability and/or Accidental Death and Dismemberment (AD&D) coverage. Please refer to the PEBB Benefits Handbook or web site for midyear change criteria.

- Submit one form per qualified status change (QSC)
- You will be notified of the coverage effective date.
- If you are adding an individual by PEBB Affidavit of Domestic Partnership or PEBB Affidavit of Dependency you must submit the appropriate affidavit **within 5 business days** of this enrollment election. If not, coverage for the individual by affidavit will terminate retroactive to the effective date.
- If applicable you must also submit documentation of an adoption agreement.

**SECTION A – EMPLOYEE OR SUBSCRIBER INFORMATION**

- Complete all items in this section.
- If making an address change only, complete Sections A and D, check the New Address box in Section A.
- If making a name change only, complete Sections A and D.

**SECTION B – QUALIFIED STATUS CHANGE INFORMATION**

**B.1** Select the QSC and enter the QSC date.

**SECTION C – REQUESTED ENROLLMENT OR CHANGES**

- Complete the appropriate sections if you wish to enroll or change your current coverage. All previous coverages will continue unless you cancel or change the level of coverages.

**C.1 Life Insurances**

**C.2 Accidental Death & Dismemberment (AD&D)**

**C.3 Disability Insurances**

**SECTION D – EMPLOYEE SIGNATURE AND AUTHORIZATION**

- Read sign and date the form.
- Make a copy for your records and submit. **Sending your forms to the wrong address will delay your change.**

**Active and Semi Independent Agency Employees:**

**Within 60 days of QSC to:** Agency/University Payroll,  
Personnel or Benefit Office

**Beyond 60 days of QSC to:** PEBB  
1225 Ferry St. SE  
Salem, OR 97301-3802  
(503)-373-1102

**COBRA and other Self-Pay Participants Only to:**  
BenefitHelp Solutions (BHS)  
PO Box 67240  
Portland, OR 97268-1240  
Portland (503)-765-3581  
Toll-free (800)-556-3137



## Life and Disability Update Form Midyear Change Request

### SECTION A - EMPLOYEE INFORMATION

**Change of:**  Name Only     Address Only

LAST NAME	FIRST NAME	MI	ID NUMBER (SSN, University ID, 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	
EMAIL ADDRESS			

### SECTION B - QUALIFIED STATUS CHANGE (QSC) INFORMATION

**B.1 Select the QSC and enter the QSC date.**

<input type="checkbox"/> Marriage Date: _____ <input type="checkbox"/> Meet domestic partner eligibility Date: _____ <b>Check a box.</b> <input type="checkbox"/> Domestic Partner by <b>PEBB Affidavit of Domestic Partnership</b> , attach affidavit (see instructions). <input type="checkbox"/> Domestic Partner by <b>Certificate of Registered Domestic Partnership</b> . Complete this form only. <input type="checkbox"/> Change PEBB Domestic Partnership by Affidavit to Certificate of Registered Domestic Partnership.  <input type="checkbox"/> Divorce, Annulment Date: _____ <input type="checkbox"/> Birth Date: _____ <input type="checkbox"/> Adoption or placement for adoption Date: _____ <input type="checkbox"/> Dependent(s) gains eligibility Date: _____	<input type="checkbox"/> Death of a dependent Date: _____ <input type="checkbox"/> Termination of domestic partnership Date: _____ <b>Check a box.</b> <input type="checkbox"/> If domestic partner was added by <b>PEBB Affidavit</b> you must attach the Termination of Domestic Partnership. <input type="checkbox"/> If domestic partner was added by <b>Certificate of Registered Domestic Partnership</b> . Complete this form only.  <input type="checkbox"/> Dependent ceases to meet eligibility Date: _____ <input type="checkbox"/> Employment status change (describe): _____ Date: _____ <input type="checkbox"/> Other (describe) _____ Date: _____
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### SECTION C – REQUESTED ENROLLMENT OR CHANGES

**C.1 LIFE INSURANCE All previous coverages will continue unless you cancel or change the level of insurance.**

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

You do not need to enroll your eligible dependents in any other PEBB plans for them to be eligible for this coverage.

**Optional Employee Life** (\$20,000 increments to \$600,000)

Check this box if you are a previous state employee and you ported your previous employee life insurance plan with Standard. Contact your agency/university benefits office for instructions on enrollment

New coverage amount \$ \_\_\_\_\_  
  
 Change coverage from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ **TOTAL**  
 (include existing coverage)  
  
 Cancel

When a medical **history statement** is required you must submit **within 5 business days** of this enrollment selection. If not, your request for insurance will be canceled.

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

Check this box if you are a previous state employee and you ported your previous spouse/domestic partner life insurance plan with Standard. Contact your agency/university benefits office for instructions on enrollment

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

- Guarantee Issue - \$20,000 (newly eligible only)
- Total** Requested Amount: \$\_\_\_\_\_ (include the \$20,000 guarantee issue)
- Change Coverage: From \$\_\_\_\_\_ to \$\_\_\_\_\_ **TOTAL**
- Cancel Coverage

When a medical **history statement** is required you must submit **within 5 business days** of this enrollment selection. If not, your request for insurance will be canceled.

**C.2 Accidental Death and Dismemberment (AD&D)** (\$50,000 increments to \$500,000)

**Coverage Tier:**

**Coverage Choice:**

- Employee only
- Employee and dependents
- New coverage (indicate amount) \$\_\_\_\_\_
- Change coverage amount from \$\_\_\_\_\_ to \$\_\_\_\_\_
- Cancel

**C.3 DISABILITY INSURANCE**

**Short Term Disability**

**Coverage Type:**

- New coverage
- Cancel

**Long Term Disability**

**Coverage Type:  
Level**

- New coverage
- Change in coverage
- Cancel

**Waiting Period  
Coverage**

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

**SECTION D - 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, unless I self pay premiums. If I self-pay the premiums, I agree to submit monthly payments by the date specified, or my coverage will terminate.

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 updates your 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

**"PEBB Use Only"**

Approved by PEBB (initials) \_\_\_\_\_ Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_ PDB updated by (initials) \_\_\_\_\_