



## Remedy for Failure to Enroll During Mandatory Medical Open Enrollment for 2010 Benefits

**- Office Use Only -**

Approved by \_\_\_\_\_ Date \_\_\_\_\_

Effective Date \_\_\_\_\_

**Submit this form ONLY because your failure to enroll during Open Enrollment will result in termination of medical coverage for your eligible dependents on Jan. 1, 2010.**

**Submit the completed form to your agency payroll or university benefits office by Dec. 31, 2009.**

### 1. Contact Information

PEBB Benefit Number (P#####), Employee ID, University ID

Last Name	First Name	MI	Agency #	Gender <input type="checkbox"/> F <input type="checkbox"/> M		
PEBB and the plans in which you enroll will send <b>all</b> benefit-related correspondence to your contact address.						
Contact Address	<input type="checkbox"/> Check if New Address	Apt #	City	State	Zip	County
Residence Zip Code	Work Zip Code	Work E-mail		Personal E-mail	(optional)	
Date of Birth _ _ / _ _ / _ _ _ _		Work Phone ( ) -		Home Phone	(optional) ( ) -	

### 2. Currently Covered Dependents

**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\* (must attach Affidavit\* of Dependency)

Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Relationship	Gender	
					M	F
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

### 3. Dependent Certification Ages 19 up to 24

I certify that dependents age 19 up to 24 listed above are eligible for coverage under PEBB rules during the 2010 Plan Year

### 4. 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.

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 supersedes all forms and submissions I previously made for 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

**Submit completed form to your agency payroll or university benefits office by Dec. 31, 2009.**

**Keep a copy of all benefit documents for your records.**