



2011 Enrollment

Eligible Retiree & Dependents

- Office Use Only -
Approved by _____ Date _____
Effective Date _____

Your choices on coverage as a PEBB retiree are determined by PEBB administrative rules. Read the Summary Plan Description to make sure you understand your choices: www.oregon.gov/DAS/PEBB/SPD.shtml

1. I am eligible to enroll because

 I'm a new retiree. Retirement Date: _____

2. I am enrolling as a

<input type="checkbox"/> PEBB Retiree	<input type="checkbox"/> PEBB Member through eligibility of a PEBB Retiree
PEBB retiree name: _____	Date of Birth: _____

3. Contact Information

PEBB Benefit Number (P#####)	Date of Birth _ / _ / _ _ _ _
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Last Name	First Name	MI	Gender <input type="checkbox"/> F <input type="checkbox"/> M
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BHS and the plans in which you enroll will send all benefit-related correspondence to your contact address.

Contact Address	<input type="checkbox"/> Check if New Address	Apt #	City	State	Zip	County
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Residence Zip Code	Home Phone	Personal E-mail
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4. Dependent Information

You may not enroll children who will turn 27 in 2011.

Attach separate sheet if necessary. If your dependent has a different contact address, fill out the next section.

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, AFF GCH=Grandchild by Affidavit (must attach the correct Affidavit*)

#	Same address? (if N, see 3.a)	Last Name	First Name	M	Birth Date (mm/dd/yyyy)	Relationship	Gender		Enroll	
							M	F	Med	Den
1	Y <input type="checkbox"/> N <input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Y <input type="checkbox"/> N <input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

You must submit a midyear change form to BHS within 30 days of the date when an individual you provide coverage to is no longer PEBB eligible. Individuals will be removed prospectively from coverage the last day of the month in which BHS receives the midyear change form from you. The exception to prospective removal from coverage is when an ex spouse, ex domestic partner or any child becomes ineligible for coverage because of divorce or dissolution of partnership. In this exception, the ineligible individuals will be removed from coverage the last day of the month in which the divorce or dissolution occurred. Late submission may affect your income taxes. In the case of retroactive terminations, you may be responsible for claims paid for the individual during the period of ineligibility. If you do not report changes of eligibility that occur before open enrollment, you may face civil or criminal charges for fraud, and PEBB may rescind coverage.

3.a If you checked N above, provide Contact Information for Dependents

List addresses for dependents that are different from yours in section 2. Include the number that corresponds to section 3.

#	Dependent's Residence Address	City	State	Zip/Country Code	County

If you listed a Domestic partner above, indicate the type of Domestic Partnership

 By PEBB Affidavit* By Registered Certificate (no copy required)

***Affidavit Information** If you are adding a child or domestic partner by affidavit, you must submit the enrollment form, affidavit, and any required documentation to BHS payroll or university benefit office within the allowed time, or your enrollment will not occur.

5. Medical and Dental Plans

Choose your benefit election and plan. You may enroll in a Full-time Plan or a Part-time Plan.

I elect to (select one):

- Enroll in PEBB Medical coverage only*
 Enroll in PEBB Dental coverage only*
 Enroll in both PEBB Medical and Dental coverage*

Medical Plan (select one)	Full-time Plan	Part-time Plan	Dental Plan (select one)	Full-time Plan	Part-time Plan
PEBB Statewide Plan	<input type="checkbox"/>	<input type="checkbox"/>	Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>	ODS Traditional	<input type="checkbox"/>	<input type="checkbox"/>
Providence Choice	<input type="checkbox"/>	<input type="checkbox"/>	ODS Preferred	<input type="checkbox"/>	
			Willamette Dental	<input type="checkbox"/>	

***You may not add medical or dental coverage during the plan change period.**

6. Medicare Coverage

If you or anyone you cover is eligible for Medicare, provide the following information. See the Medicare card for effective dates.

Name	Part A Effective Date	Part B Effective Date
	__ / __ / ____	__ / __ / ____
	__ / __ / ____	__ / __ / ____

7. Subscriber 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.

I understand that:

- A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines
- Knowingly making a false statement may subject me to termination of enrollment, denial of future enrollment, or civil damages.

I also understand that if I fail to report on this enrollment form a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.

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 false claims.

 Retiree/Subscriber Signature

 Date

Send to:	Benefit Help Solutions	Portland (503) 765-3581
	PO Box 67240	Toll-free (800) 556-3137
	Portland, OR 97268-1240	Toll-free Fax (888) 393-2943

Keep a copy of all benefit documents for your records.