



2011 Enrollment

Self-Pay Participant

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

See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml

1. I am enrolling as a

New Participant. Eligibility Date: _____

2. I am

<input type="checkbox"/> OLCC Agent	<input type="checkbox"/> Post Doc/J1 Visa	<input type="checkbox"/> Blind Business Enterprise Employee
<input type="checkbox"/> Foster Parent (attach copy of Foster Parent Certificate)	<input type="checkbox"/> Nurse working less than half time	

3. Contact Information

PEBB Benefit Number (P#####)

Last Name	First Name	MI	Agency #	Gender
				<input type="checkbox"/> F <input type="checkbox"/> M

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
Residence Zip Code	Work Zip Code	Work E-mail	Personal E-mail	(optional)		
Date of Birth	Work Phone	Home Phone	(optional)			
__ / __ / __ __ __ __						

4. Dependent Information

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

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

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 below)	Last Name	First Name	M	Birth Date (mm/dd/yyyy)	Relationship	Gender		Enroll		Drop
							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"/>	<input type="checkbox"/>
2	Y <input type="checkbox"/> N <input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Y <input type="checkbox"/> N <input type="checkbox"/>						<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.

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** 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

Blind Business Enterprise Employees may enroll only in Medical coverage.

I elect to (select one):

- Enroll in PEBB Medical 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 Option	<input type="checkbox"/>	
			Willamette Dental	<input type="checkbox"/>	

6. Medicare Coverage

The following individuals are covered by Medicare:

- Not Applicable Me Spouse and Domestic Partner A Dependent Child
Name: _____ Name: _____

7. Participant 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.

Participant 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.