

Health Assessment Exemption Request

2016 PEBB Health Engagement Model (HEM)

Use this form if you are enrolling in the 2016 HEM and believe you, or your PEBB covered spouse/domestic partner, needs an exemption from completing the required health assessment.

PEBB's 2016 HEM Participant status requires completion of the following before October 31, 2015:

1. **Enrollment** in the 2016 HEM program during PEBB's Open Enrollment period (October 1 through October 31, 2015)
2. **Completion** of the employee's current (2015) medical plan health assessment by both the employee and a PEBB covered spouse or domestic partner, between September 1 and October 31, 2015. (Contact PEBB if you do not have a 2015 medical plan, or your medical plan identification)

Complete one form for each person requiring an exemption.

- The form must be completed and signed by the individual requesting the exemption, or if unable by the subscriber for the individual.
- **You must submit the completed form to your 2015 PEBB medical plan between September 1 and October 31, 2015. Your plan will determine an approval or a denial and notify you.**
- The form does not exempt any other individual except the person named on the form. If approved, only the individual named on this form is considered as having completed their individual 2016 HEM health assessment requirement.
- If the request is denied, the individual named remains subject to the HEM program annual health assessment requirement.

The health plan will notify the subscriber by letter of the exemption request approval or denial.

NOTE: An approved exemption for an individual IS NOT valid from plan year to plan year. An exemption must be requested for each new HEM plan year.

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Section 1. Information of individual needing exemption: (please print)

First Name _____ Last Name _____

Date of Birth _____ Phone Number _____

My 2015 PEBB Medical Plan is: _____

My medical plan ID number (found on your plan's ID card) _____

Section 2. Reason for exemption.

The member listed in Section 1 is unable to complete the 2016 HEM requirements and is requesting exemption for the following reasons: **(Check only one. No other reasons are allowed.)**

_____ **Serving in the military overseas**

_____ **Out of the Country**

_____ **Incarcerated**

_____ **Medical condition or disability** (Don't include specific medical or disability information on this form)

Section 3 Confirmation.

I understand that a subscriber enrolled in the 2016 PEBB HEM, and their covered spouse or domestic partner, must complete the HEM requirements to be a 2016 HEM Participant. I also understand that if approved, the request exempts only the individual named in Section 1 from completing the required 2016 HEM program health assessment. My signature below confirms my agreement and that the information provided on this form is true and accurate.

Signature _____

Print Name _____ Date _____

Fax or mail the form to your current 2015 medical plan.

AllCare PEBB	Kaiser (HMO & Deductible)	Moda(Synergy & Summit)
AllCare PEBB Attn: Nicole LaFond, 740 SE 7 th Street, Grants Pass, OR 97526 Fax: 541-471-3784	Kaiser Health Plan NW Attn: HealthWorks NW 500 NE Multnomah St. Portland, OR 97232-2023 Fax: 866-635-2837 Email: HealthWorksNW@kp.org	MODA 601 SW Second Ave. Attn: Jim Gonzalez Portland, OR 97204 Email: ha@modahealth.com
Providence (Statewide & Choice) PO Box 3125, Portland, OR 97208 Email: pebb.help@providence.org Fax: 503-574-8155	Trillium Attn: Sophia Meyer, PO Box 43277, Portland, OR 97208 Email: Sophia.meyer@providenceee.org Fax: 503-574-7543	