



November 2015 Newly Eligible Employee Open Enrollment Form For 2016 Benefits

- Office Use Only -

Approved by: _____ Date: _____

Effective Date: _____

If you are a newly eligible employee hired in November 2015 you must use this form to complete open enrollment selections for 2016 even if you are not making any changes to your new hire enrollments.

- Submit this form to your agency/University benefit office to process.
- This form does not include Flexible Spending Accounts or Commuter accounts for 2016. If you want either of those account types you must complete and submit the appropriate forms.
- Forms are available at: www.oregon.gov/DAS/PEBB

Complete Sections 1 through 5, and sign and date section 10.

Complete sections 6 through 9 ONLY if you are enrolling or making changes to your optional benefits for 2016.

1. Contact Information You must complete all fields.

PEBB Benefit Number (P#####), OR# or University ID

Last Name _____ First Name _____ M _____ Agency _____ Gender
 M F

Contact Address Check if New Address _____ Apt # _____ City _____ State _____ Zip _____

Residence Zip Code _____ Work Zip Code _____ Work Email _____ Personal Email (optional) _____

Date of Birth (mm/dd/yyyy) _____ Work Phone _____ Home Phone (Optional) _____

Are you Medicare Eligible? No Yes This will not affect enrollment.

Ethnicity: Hispanic Non-Hispanic Non-Latino Unknown Refuse

Race: Asian White Unknown Refuse Other

Black/African American American Indian Alaska Native Native Hawaiian/Other Pacific Islander

2. Family Coverage List all eligible family members you currently have covered and want to continue coverage for in 2016. Attach separate sheet if necessary. You cannot enroll a dependent child who will turn 27 in 2016. **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

Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender		Enroll		
					M	F	Med	Den	Vision
Spouse/Domestic Partner					<input type="checkbox"/>				

Address: Complete only if different than Address in Section 1

Is This Dependent Medicare Eligible? No Yes This will not affect enrollment.

Ethnicity: Hispanic Non-Hispanic Non-Latino Unknown Refuse

Race: Asian White Unknown Refuse Other

Black/African American American Indian/Alaska Native Native Hawaiian/Other Pacific Islander

***If you listed a Domestic Partner, mark the type of Domestic Partnership**

Registered Certificate of Domestic Partnership (Copy not required) means a certificate issued by an Oregon county clerk to two individuals of the same sex after they file a Declaration of Domestic Partnership with the county clerk.

PEBB Domestic Partner Affidavit is for a partnership between an eligible employee and an individual of the opposite or same sex without a Certificate of Registered Domestic Partnership. If you previously provided an affidavit for your current partnership, you do not have to provide a new affidavit. If you are **adding coverage for a new domestic partner** by affidavit you must complete and submit to your agency the enrollment form and affidavit.

NOTE: Adding a Domestic Partner or Domestic Partner's children to your coverage when they are not your tax dependent(s) will lower your monthly net pay. For information see the Summary Plan Description <http://www.oregon.gov/DAS/PEBB/2015Benefits/SPD.pdf> page 17.

- If your partner or domestic partner's children are your federal tax dependents you can complete and submit the Domestic Partner Certification for Dependent Tax Status **each plan year** to your agency payroll. Imputed value won't be added to your pay. <http://www.oregon.gov/DAS/PEBB/Pages/forms.aspx>
- Adding a child by Affidavit of Dependency requires legal documentation, affidavit, and enrollment form. <http://www.oregon.gov/DAS/PEBB/Pages/forms.aspx>
- Adding a Grandchild by Affidavit to your enrollment for the first time, requires special eligibility and additional forms. Contact your agency or PEBB for more information.
- **When an enrollment requires additional documents and affidavits your payroll or university benefit office must receive them along with this form.**

Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
Child					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Address: Complete only if different than Address in Section 1						
Is This Dependent Medicare Eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes This will not affect enrollment.						
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse						
Race: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse <input type="checkbox"/> Other						
<input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander						
Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
Child					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Address: Complete only if different than Address in Section						
Is This Dependent Medicare Eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes This will not affect enrollment.						
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse						
Race: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse <input type="checkbox"/> Other						
<input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander						
Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
Child					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Address: Complete only if different than Address in Section						
Is This Dependent Medicare Eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes This will not affect enrollment.						
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse						
Race: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse <input type="checkbox"/> Other						
<input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander						

3. Medical and Dental Plans (Core Benefits) Full Time employees may choose only from full time plans. Part time employees are eligible for part time or full time plans. See your agency benefits office for your premium share information.

Medical Plans: Some plans have specific service areas and may not be available to you, be sure to review plan availability for your area.

- Opt Out is a medical plan choice with dental and vision coverage available.
- **If you enroll in a PEBB medical plan (not Opt Out) YOU MUST COMPLETE SECTIONS 5 AND 6.**

Vision Plan: The full time Kaiser HMO and full time Kaiser Deductible plan include Kaiser vision coverage, and are not eligible for VSP coverage. All other medical plans, (full or part-time) including the Kaiser part-time plans, are eligible for enrollment in VSP coverage.

Medical: Check one box below for your 2016 medical plan **Dental:** Check one box below for your 2016 dental plan. You must be enrolled in a medical plan to enroll in a dental plan.

	Full Time	Part Time		Full Time	Part Time
Kaiser Permanente HMO (Kaiser vision with full time plan)	<input type="checkbox"/>	<input type="checkbox"/>	Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser Deductible (Kaiser vision with full time plan)	<input type="checkbox"/>	<input type="checkbox"/>	MODA Premier	<input type="checkbox"/>	<input type="checkbox"/>
Moda Summit	<input type="checkbox"/>	<input type="checkbox"/>	MODA PPO	<input type="checkbox"/>	N/A
Moda Synergy	<input type="checkbox"/>	<input type="checkbox"/>	Willamette Dental	<input type="checkbox"/>	N/A
All Care PEBB	<input type="checkbox"/>	<input type="checkbox"/>			
PEBB Statewide PPO	<input type="checkbox"/>	<input type="checkbox"/>			
Providence Choice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I do not want to Enroll in dental plan (Waive enrollment)		

Vision (VSP) Enroll (You must be enrolled in a medical plan) I do not want to enroll in Vision

Medical Opt Out – You will receive cash in lieu of enrollment in a PEBB medical plan. You must have other medical insurance coverage to enroll in Opt Out. Participation or enrollment in the Oregon Health Plan/Medicaid, Veteran’s Benefit Administration Programs or Student Health Insurance does not qualify for PEBB Opt Out. Attach or submit your proof of your other medical coverage to your agency if you are new to this choice for 2016.

- If you enroll in Medical Opt Out, basic employee life is required and you pay a premium share.
- If you currently Opt Out of Medical in 2015 and want to continue in 2016 you do not need to provide proof of other medical coverage.
- If you are new to Opt Out enrollment, your agency must receive your proof other medical coverage by Nov. 7, 2015 or your enrollment will not take effect.
- If you are a full time employee the Opt Out dollar amount you receive is \$233, which is taxable, less \$1 for basic life. Part-time employees opt out amount is pro-rated. See your payroll.
- Opt Out enrollees can enroll in dental, vision, and all the optional plans. Employees who Opt Out cannot enroll in the HEM program.

Decline All PEBB Benefits You do not receive cash in lieu of the medical coverage and you cannot enroll in any of the PEBB plans. If you decline core benefits (medical/dental/vision/employee basic life), you’re choosing to not participate in any of the PEBB programs.

4. Other Spousal/Partner Employer Group Coverage If you enroll in a Medical plan and do not complete Section 5, a surcharge (\$50) will be deducted each month from your 2016 pay.

When your spouse or domestic partner is enrolled in your PEBB medical coverage and has access to medical coverage from their employer's sponsored group plan (i.e., a non- State of Oregon- -agency employer) and waives the coverage (doesn't enroll), the following amount will be added to your monthly premium for 2016 PEBB coverage: \$50.00

Check one box:

- My spouse/domestic partner has PEBB coverage as an eligible employee (Includes Opt out) (\$0)
- My spouse/domestic partner has other employer group coverage available and enrolls for that coverage. (\$0)
- My spouse/domestic partner has other-employer group coverage available, waives that coverage and is enrolled in PEBB. (\$50)
- My spouse/domestic partner does not have other-employer group coverage available.(\$0)
- I do not cover a spouse or domestic partner in a PEBB medical plan. (\$0)

5. Tobacco Use If you enroll in a Medical plan and do not complete Section 6, a tobacco surcharge (\$25.00 per employee and \$25.00 for spouse/partner enrolled in medical) will be deducted each month from your 2016 pay for PEBB coverage.

When you or your spouse/domestic partner currently uses tobacco the \$25 per tobacco user will be deducted from your monthly pay for 2016 PEBB coverage. An employee and spouse/domestic partner who currently don't use tobacco will not have a charge.

Check one box:

- I currently use tobacco and, my spouse/domestic partner currently does not use tobacco. (\$25)
- I currently do not use tobacco, and my spouse/domestic partner currently uses tobacco.(\$25)
- Both my spouse/domestic partner and I currently use tobacco.(\$50)
- Both my spouse/domestic partner and I currently do not use tobacco.(\$0)
- I currently use tobacco and do not have a spouse/domestic partner covered in PEBB. (\$25)
- I currently do not use tobacco and do not have a spouse/domestic partner covered in PEBB. (\$0)
- I do not enroll in PEBB medical plans.
- My or My spouse's or domestic partners' provider advised not to quit using tobacco (Medical Waiver). (\$0)

6. Optional Life Insurance (New or additional coverage above your current amount requires a medical history statement.)

Dependent Life Insurance \$5,000 of coverage for each PEBB eligible dependent (including spouse or domestic partner). Medical history is **not** required. Premium rate is \$1.29 per month. <http://www.oregon.gov/das/pebb/pages/opben/DepLife.aspx>

Enroll for Coverage

Cancel Coverage

Employee Optional Life Insurance Medical History Statement required for new enrollment and all increases (\$20,000 increments, maximum \$600,000). <http://www.oregon.gov/das/pebb/pages/opben/opeelife.aspx>

Enroll or Increase Coverage

Cancel Coverage

Reduce Coverage to:

Your Current Amount

Additional Amount Requested
(Medical History Required by Nov. 7, 2015)

Total Amount

\$_____ +

\$_____ =

\$_____

Tobacco use status (you must check one)

I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)

I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

Spouse or Domestic Partner Optional Life Insurance Medical History Statement required for new enrollment and all increases (\$20,000 increments, maximum \$400,000). <http://www.oregon.gov/das/pebb/pages/opben/SDPLive.aspx>

Enroll or Increase Coverage

Cancel Coverage

Reduce Coverage to:

Your Current Amount

Additional Amount Requested
(Medical History Required by Nov. 7, 2015)

Total Amount

\$_____ +

\$_____ =

\$_____

Tobacco use status (you must check one)

I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)

I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

7. Disability Insurance (replaces a portion of salary when employee is eligible for the benefit)

<http://www.oregon.gov/DAS/PEBB/Pages/opben/STD.aspx>

Short Term Disability (The monthly premium rate is 0.0064 times your gross monthly salary)

- Enroll for Coverage
 Cancel Coverage

Long Term Disability (The monthly premium is determined by the rate (listed next to the plan) time your gross monthly salary

<http://www.oregon.gov/DAS/PEBB/Pages/opben/LTD.asp>

Enroll for Coverage (select one)

Change Coverage (select one)

Cancel Coverage

Waiting Periods – Coverage Level

90 days – 60% (.0051)

90 days – 66 2/3% (.0106)

180 days – 60% (.0018)

180 days 66 2/3% (.0027)

8. Accidental Death Dismemberment (AD&D) <http://www.oregon.gov/DAS/PEBB/Pages/opben/ADD.aspx>

Cancel Coverage

Employee only Coverage (premium = \$1 per \$50,000)

Total Coverage Amount \$_____ (\$50,000 increments, max \$500,000)

Employee & Dependent Coverage (premium = \$1.70 per \$50,000)

Total Coverage Amount \$_____ (\$50,000 increments, max \$500,000)

9. Beneficiary Designation Entity Key: I – Individual, W – Will, T = Living Trust. Total of primary percentages must = 100%.

Total of contingent percentages must = 100% You can change your beneficiary designation yourself anytime during the year at

<http://www.pebb.benefits.oregon.gov/members/lpb.main>

Standard Order of Survivorship (No beneficiary listed)

Designate the following as beneficiary. (List beneficiary)

Name	Relationship	Address	Entity	Primary	Contingent	Whole %
				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	

10. 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.

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.

Employee Signature

Date

If you DO NOT want premiums deducted on a before tax basis, initial here_____.

Submit completed form to your agency payroll or university benefits office

Keep a copy of your benefit forms for your records.

Any alteration of this form may result in it being ineffective.