PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

2016 Eligible Retiree & Dependents Enrollment

- Office use only -

Approved by: _____ Date:_____

Effective date:_____

1. I am eligible to enroll as:

☐ **New retiree.** PEBB retirees have 60 days from the loss of active employee coverage to enroll in PEBB retire coverage.
Retirement date:

☐ **Eligible by relationship to a PEBB retiree.**
PEBB retiree name:
PEBB retiree date of birth:

2. Contact information: **You must complete all fields. (**Please print)

PEBB Benefit Number (P########)

Last name | First name | M | Agency | Gender ☐ M ☐ F

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

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 affect your 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

Are you serving or did you ever serve in the Military? ☐ No ☐ Yes

Do you authorize PEBB to send your name and address to Oregon Department of Veteran's affairs (ODVA) for the purpose of receiving benefit information? ☐ No ☐ Yes

3. Family coverage

List all eligible family members you currently have covered and want to continue coverage for. You cannot add dependents during the plan change period. Retirees may only add eligible family members to coverage by using a qualifying midyear change event. You cannot continue coverage for an adult 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 M	Gender F	Enroll Med	Enroll Den	Enroll Vision
Spouse/domestic partner				{Select}	☐	☐	☐	☐	☐

Address: Complete only if different than address in Section 1

Is this dependent Medicare eligible? ☐ No ☐ Yes This will 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

Last name	First name	M	Birth date mm/dd/yyyy	Relationship	Gender M	Gender F	Enroll Med	Enroll Den	Enroll Vision
Child				{Select}	☐	☐	☐	☐	☐

Address: Complete only if different than address in Section 1

Is this dependent Medicare eligible? ☐ No ☐ Yes This will 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

Last name	First name	M	Birth date mm/dd/yyyy	Relationship	Gender M	Gender F	Enroll Med	Enroll Den	Enroll Vision
Child				{Select}	☐	☐	☐	☐	☐

Address: Complete only if different than address in Section 1

Is this dependent Medicare eligible? ☐ No ☐ Yes This will 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

4. Medical and dental plans (core benefits)

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

- You may enroll in either a full time or a part time plan.

Vision and dental plans: Vision Service Plan (VSP) and Dental plans are stand-alone plans. Enrollment in a medical plan is not required for you to enroll in dental or vision. If you enroll in either the full time Kaiser HMO or the Kaiser Deductible full time medical plan, Kaiser Vision is included and you cannot enroll for vision through VSP.

Medical: Check one box below for your 2016 medical plan.

	Full time	Part time
Kaiser Permanente HMO (Kaiser Vision with full time plan only)	☐	☐
Kaiser Deductible (Kaiser Vision with full time plan only)	☐	☐
Moda Summit	☐	☐
Moda Synergy	☐	☐
All Care PEBB	☐	☐
PEBB Statewide PPO	☐	☐
Providence Choice	☐	☐

Dental: Check one box below for your 2016 dental plan.

	Full time	Part time
Kaiser Permanente	☐	☐
Moda Premier	☐	☐
Moda PPO	☐	N/A
Willamette Dental	☐	N/A

☐ I do not want to enroll in a dental plan.

Vision (VSP): ☐ Enroll ☐ I do not want to enroll in Vision

5. Other spousal/partner employer group coverage

When your spouse or domestic partner **is enrolled in your PEBB medical coverage** and has access to medical coverage through their employer's sponsored group plan (i.e., a non-Oregon-state-agency employer) and waives the coverage (does not 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 overage 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)
- ☐ I do not enroll in PEBB retiree medical plans.

6. Tobacco use

When you or your spouse/domestic partner currently uses tobacco, $25 per tobacco user will be added to your monthly premium for the 2016 plan year. A retiree 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 partner's provider advised not to quit using tobacco (medical waiver). ($0)

7. Retiree 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.

_____ _____

Retiree signature Date

Submit complete form to:	**BenefitHelp Solutions**	Portland: 503-765-3581
	PO Box 40548	Toll free: 1-800-556-3137
	Portland, OR 97240	Fax: 503-765-3453 or 1-888-393-2943

Keep a copy of your benefit forms for your records.

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