



## 4. Family coverage

List all eligible family members you want 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 BenefitHelp Solutions the enrollment form and affidavit. [www.oregon.gov/DAS/PEBB/Pages/16DPTaxes.aspx](http://www.oregon.gov/DAS/PEBB/Pages/16DPTaxes.aspx).
- Adding a child by affidavit requires legal documentation, affidavit, and enrollment form.
- All legal documentation and affidavits must be attached with this form to BenefitHelp Solutions.

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.						
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse						
<b>Race:</b> <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 1						
Is this dependent Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes This will not affect enrollment.						
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse						
<b>Race:</b> <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						

## 5. 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

**Vision plan:** Vision Service Plan (VSP) is a stand-alone plan. Enrollment in a medical plan is not required to enroll in vision. If you enroll in either the Kaiser HMO or Kaiser Deductible full time medical plan they include Kaiser Vision, you cannot enroll in VSP.

<b>Medical: Check one box below for your 2016 medical plan.</b>			<b>Dental: Check one box below for your 2016 dental plan.</b> To enroll in dental you must be enrolled in a medical plan choice.		
	Full Time			Full Time	
Kaiser Permanente HMO (Kaiser Vision)	<input type="checkbox"/>		Kaiser Permanente	<input type="checkbox"/>	
Kaiser Deductible (Kaiser Vision)	<input type="checkbox"/>		Moda Premier	<input type="checkbox"/>	
Moda Summit	<input type="checkbox"/>		Moda PPO	<input type="checkbox"/>	
Moda Synergy	<input type="checkbox"/>		Willamette Dental	<input type="checkbox"/>	
All Care PEBB	<input type="checkbox"/>		<input type="checkbox"/> I do not want to enroll in a dental plan		
PEBB Statewide PPO	<input type="checkbox"/>				
Providence Choice	<input type="checkbox"/>				

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

## 6. 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 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)
- I do not enroll in PEBB retiree medical plans.

## 7. 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 participant 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)

## 8. 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. 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.

\_\_\_\_\_  
Participant signature

\_\_\_\_\_  
Date

**Submit complete form to:**

**BenefitHelp Solutions**  
**PO Box 40548**  
**Portland, OR 97240**

Portland: 503-765-3581

Toll Free: 1-800-556-3137

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.**