



**Self-Pay Participant
Open Enrollment
Oct. 1 – Oct. 31, 2016**

- Office Use Only -

Approved by: _____ Date: _____

Effective Date: _____

This is a mandatory Open Enrollment. This means if you are currently enrolled in PEBB benefits, you must actively enroll for the 2017 plan year, even if you want the same enrollments as in 2016.

- Do not use this form to add a new dependent (new spouse, domestic partner, child) if you want the coverage in 2016. Instead, use the Midyear Change form at <http://www.oregon.gov/oha/pebb/2016Benefits/MidyearChange.pdf> to add individuals to current 2016 coverage. Use this form to enroll yourself and all eligible dependents in coverages for 2017. Blind Business Enterprise agents may enroll in medical only. All other self-pay participants may enroll in medical and dental plans

- Self-Pay participants do not enroll in the PEBB Health Engagement Model (HEM)

Complete Sections 1 through 6, and sign and date section 7. (Send completed form to BenefitHelp Solutions)

1. I am

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

2. Contact Information You must complete all fields. (Please Print)

PEBB Benefit Number (P#####)

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

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 not affect enrollment.

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

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

3. Family Coverage List all eligible family members you want coverage for in 2017. Attach separate sheet if necessary. **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 Med Den Vision		
					M	F			
Spouse/Domestic Partner					<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? 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

3a. If you listed a Domestic Partner, mark the type of Domestic Partnership

Registered Certificate of Domestic Partnership (Certificate copy not required) You have a registered certificate issued by an Oregon county clerk to two individuals of the same sex.

PEBB Domestic Partner Affidavit. You are an eligible employee in a partnership with an individual of the opposite or same sex without a Certificate of Registered Domestic Partnership. If you are **adding a new domestic partner** by affidavit you must submit the enrollment form and affidavit by Nov. 4, 2016, to your agency. The individual's enrollment will not take effect if the affidavit is not submitted. If you previously provided an affidavit for your current partnership, you don't need to provide another.

3b Eligible Dependent Children

- Children who will be 27 in 2017 are not eligible. PEBB automatically ends coverage on December 31, for children who are 26 in 2016. You do not need to do anything.
- Covering Children by Dependency or Grandchildren requires submission of the enrollment and appropriate affidavit, and may require legal documentation. Your agency must have all submissions of affidavits or legal paper work by Nov. 4 or the individual's coverage will not go into effect.

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 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 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 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						

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

Medical: Check one box below for your 2017 medical plan **Dental:** Check one box below for your 2017 dental plan To enroll in dental you must be enrolled in a medical plan choice.

	Full Time			Full Time	
AllCare PEBB	<input type="checkbox"/>		Kaiser Permanente	<input type="checkbox"/>	
Kaiser Deductible (Kaiser vision)	<input type="checkbox"/>		MODA Premier	<input type="checkbox"/>	
Kaiser HMO (Kaiser vision)	<input type="checkbox"/>		MODA PPO	<input type="checkbox"/>	
Moda Summit	<input type="checkbox"/>		Willamette Dental	<input type="checkbox"/>	
Moda Synergy	<input type="checkbox"/>				
PEBB Statewide PPO	<input type="checkbox"/>				
Providence Choice	<input type="checkbox"/>		<input type="checkbox"/> Decline Dental Plan Enrollment		

4a. Vision Plan: Both the full time Kaiser HMO and Kaiser Deductible plan include Kaiser vision coverage, and are not eligible for VSP. All other medical are eligible for VSP enrollment.

Enroll VSP Basic Plan	<input type="checkbox"/>	VSP Basic and VSP Plus information at: www.oregon.gov/oha/pebb/benefits/vision.pdf
Enroll VSP Plus - Includes the Basic Plan and more	<input type="checkbox"/>	
I Decline all VSP Enrollment	<input type="checkbox"/>	

5. Other Spousal/Partner Employer Group Coverage If you enroll in Medical and do not complete Section 5 a surcharge (\$50.00) will be added to your monthly premium cost

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) but does not enroll in it, the following amount will be added to your monthly premium for 2017 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.

6. Tobacco Use If you enroll in Medical and do not complete Section 6 a surcharge (\$50.00) will be added to your monthly premium cost

When you or your spouse/domestic partner currently uses tobacco, \$25 per tobacco user will be added to your monthly premium for the 2017 plan year. If both you and your spouse/domestic partner currently don't use tobacco you 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 spouse's or domestic partners' provider advised not to quit using tobacco (Medical Waiver). (\$-0-)

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. 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 by Oct. 31, 2016 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.**