

Health Assessment Exemption Request

2017 PEBB Health Engagement Model (HEM)

Use this form if you are enrolling for the 2017 HEM program and believe you need an exemption from completing the required health assessment.

Exemption requests must be submitted for each new plan year. A previous year exemption approval IS NOT valid for 2017.

To be a 2017 HEM Participant you must complete the following before October 31, 2016:

1. **Enroll** in the 2017 HEM program during PEBB's Open Enrollment period (October 1 through October 31, 2016)
2. **Complete** an individual health assessment at your 2016 medical plan website between September 1 and October 31, 2016. (Contact PEBB if you do not have a 2016 medical plan, or your medical plan identification number)

If you believe you cannot complete #2 because of one of the reasons specified on the following form, complete and submit the form to your current medical plan between September 1 and October 31, 2016. Your plan will make a determination and notify you of your exemption status.

- If approved, you do not need to complete your medical plan's 2017 HEM health assessment.
- If the request is denied, and you enroll for the 2017 HEM you are responsible to complete your health assessment during the required timeframe to be a Participant.

PEBB will not know your HEM status for several weeks after OPEN Enrollment closes October 31, 2016.

Health Assessment Exemption Request 2017 PEBB Health Engagement Model (HEM)

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

First Name _____ Last Name _____

Date of Birth _____ Phone Number _____

My 2016 PEBB Medical Plan is: _____

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

Section 2. Reason for exemption.

I am unable to complete the 2017 HEM requirements and 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 medical or disability information on this form)

_____ **The health assessment does not meet my gender identity needs.**

Section 3 Confirmation.

I understand if I enroll in the 2017 PEBB Health Engagement Model (HEM) I must complete the program requirements to be a 2017 HEM Participant. I understand this request, if approved, exempts me from completing the required 2017 HEM program health assessment. My signature below confirms my agreement and that the information provided on this form is true.

Signature _____ Date _____

Are you the subscriber? _____ Yes _____ No

AllCare PEBB	Kaiser (HMO & Deductible)	Moda(Synergy & Summit)
AllCare PEBB Attn: Debbie Jarrett 740 SE 7 th Street, Grants Pass, OR 97526 Fax: 541-471-3784	Kaiser Health Plan NW Rewards Customer Service300 Lakeside Drive Suite 2611 Oakland, CA 94612 FAX: 866-356-5017 Email: Product-Operations@kp.org	MODA 601 SW Second Ave. 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

