

## **Self-Pay Open Enrollment Correction for 2017 Plan Year**

Use this form to request a correction to an error made while enrolling in plans for the 2017 plan year.

**Note:** Not enrolling in a 2017 benefit plan during Open Enrollment is not a correctable enrollment error. If you did not enroll during Open Enrollment, you cannot make changes to plan election or coverage. However, you can elect a different participation status in a Health Improvement or Cost Containment Program.

### **Directions:**

- Check the appropriate box in Section 1 and Section 2
- Complete Section 3 only if you have changes to your 2017 dependents
- To correct an enrollment error, complete only the sections(s) of the form related to that error. Example: You meant to enroll in Providence Choice but your benefit summary shows that you enrolled in PEBB Statewide. Check the box next to “Providence Choice” in Section 5.
- To correct a status error in the Current Tobacco Use or Spousal Other Group Coverage sections. Complete Section 6 and 7.
- Review, sign and date Section 8.
- Deliver, mail or fax the completed, signed form to BenefitHelp Solutions. Include any other needed documents.

### **Deadlines for correcting open enrollment errors:**

- To correct an open enrollment error before 2017 benefits go into effect, you must submit this completed form no later than Dec. 31, 2016. To correct an open enrollment error after benefits go into effect, you must submit this completed form no later than Jan. 31, 2017.

### **Deadlines for avoiding a an addition to monthly cost due to Tobacco Use or Spousal Other Group Coverage:**

- To avoid a January surcharge added to your premium payment for an incorrect status in these programs, you must complete Sections 1, 2, 6, 7 and review and sign and date section 8 of this form and submit it to BenefitHelp Solutions office by December 12, 2016. To avoid the surcharge in February the date is Jan. 12, 2017.
- Note: After January 1<sup>st</sup> corrections to surcharges are prospective to the first of the month following receipt of the form. Surcharges are not refunded.



**Self-Pay Participant  
Open Enrollment  
Correction  
2017 Plan Year**

- Office Use Only -

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

Effective Date: \_\_\_\_\_

**1. Correction Requested:**

I am submitting this form to correct an error I made in enrolling in a benefit plan, or correcting my 2017 dependents.

I am submitting this form to correct my status for Tobacco Use or Spouse other Coverage surcharge.

**2. I am**

OLCC Agent

Post Doc/J1 Visa

Blind Business Enterprise

Foster Parent (attach copy of Foster Parent Certificate)

Nurse working less than half time

**3. Contact Information You must complete all fields.**

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 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

**4. Family Coverage** List only the PEBB eligible family members that a 2017 enrollment error was made for (add/remove) 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		
					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

**4a. 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 along with this form 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.

**4c. Eligible Dependent Children** List only the PEBB eligible family members that a 2017 enrollment error was made for (add/remove)

- 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. BenefitSolutions must have all submissions of affidavits or legal paper work along with this form or the individual's coverage will not go into effect.

Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender		Enroll		
					M	F	Med	Den	Vision
Child					<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

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?  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

### 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

**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		

**5a. 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.

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

**6. 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. If you are correcting an open enrollment error, check the box that applies.

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.

**7. 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. If you are correcting an open enrollment error, check the box that applies.

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. 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  My spouse's or domestic partners' 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**

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.**