



November 2016 Newly Eligible Employee Open Enrollment Form For 2017 Benefits

Office Use Only

Approved by: _____

Date: _____

Effective Date: _____

If you are a newly eligible employee hired in November 2016 you must use this form to complete open enrollment selections for 2017 even if you are not making any changes to your (2016) new hire enrollments. (NOTE: 2017 HEM is not available to new employees 11/1 forward.)

- Submit this form to your agency/University benefit office to process.
- This form does not include Flexible Spending Accounts or Commuter accounts for 2017. If you want either of those account types you must complete and submit the appropriate forms.
- Forms are available at: www.oregon.gov/DAS/PEBB

Complete Sections 1 through 5, and sign and date section 10.

Complete sections 6 through 9 ONLY if you are enrolling or making changes to your optional benefits for 2017.

1. Contact Information You must complete all fields.

PEBB Benefit Number (P#####), OR# or University ID

Last Name _____ First Name _____ M _____ Agency _____ Gender
 M F

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

2. Family Coverage List all eligible family members you want to provide coverage for in 2017. Attach separate sheet if necessary.

Spouse/Domestic Partner Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender		Enroll		
					M	F	Med	Den	Vision
					<input type="checkbox"/>				

Address: Complete only if different than 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

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

Registered Certificate of Domestic Partnership (Copy not required) You have a registered certificate issued by an Oregon county clerk to you and your same sex partner.

PEBB Domestic Partner Affidavit is a partnership between an eligible employee and an individual of the opposite sex, or same sex without a Certificate of Registered Domestic Partnership. If you are **adding a new domestic partner** by affidavit you must submit an affidavit by November 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 a new affidavit.

NOTE: Adding a Domestic Partner or Domestic Partner's children to your coverage when they are not your tax dependent(s) will lower your monthly net pay. For information see the Summary Plan Description <http://www.oregon.gov/oha/pebb/Pages/spd.aspx> page 17.

Is your partner, or are your domestic partner's children your federal tax dependents? If so complete and submit to your agency the Domestic Partner Certification for Dependent Tax Status **each plan year**. Imputed value won't be added to your pay.

<http://www.oregon.gov/oha/pebb/Pages/forms.aspx>

When an enrollment requires additional documents and affidavits your payroll or university benefit office must receive them by Nov. 4, 2016, or the individual's coverage will not take effect January 1, 2017.

2.b Eligible Dependent Children – List the eligible children you want to provide coverage for in 2017. Attach a separate sheet) if necessary.

- Children who will be 27 in 2017 are not eligible. PEBB ends coverage 12/31 for children who were 26 in 2016. You do not need to do anything.
- Adding (new) Children by Dependency or Grandchildren to your enrollment will require submission of the enrollment, appropriate affidavit, and may require legal documentation. Affidavits or legal documents are required to be submitted with this form to your payroll/HR office.

Child Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vision

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

Child Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vision

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

2b. Eligible Dependent Children - continued

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

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

4. Core Benefits (Medical/Dental/Vision) Full Time employees are eligible for full time plans only. Part time employees are eligible for part time or full time plans. See your agency benefits office for premium share information.

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

- Opting Out is a choice of receiving cash instead of choosing a medical plan enrollment. Opt Out enrollees are eligible for dental, vision, and optional coverages. To Opt Out, complete Section 4c
- **If you are enrolling for a PEBB medical plan (not Opt Out) YOU MUST ALSO COMPLETE SECTIONS 5 AND 6.**

Medical: Check one box below for your 2017 medical plan			Dental: Check one box below for your 2017 dental plan. You must be enrolled in a medical plan or Opt Out to enroll in a dental plan.		
	Full Time	Part Time		Full Time	Part Time
AllCare PEBB	<input type="checkbox"/>	<input type="checkbox"/>	Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser Deductible (Kaiser vision included with full time plan)	<input type="checkbox"/>	<input type="checkbox"/>	MODA Premier	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser HMO (Kaiser vision included with full time plan)	<input type="checkbox"/>	<input type="checkbox"/>	MODA PPO	<input type="checkbox"/>	N/A
Moda Summit	<input type="checkbox"/>	<input type="checkbox"/>	Willamette Dental	<input type="checkbox"/>	N/A
Moda Synergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I Decline all Dental Plan Enrollment		
PEBB Statewide PPO	<input type="checkbox"/>	<input type="checkbox"/>			
Providence Choice	<input type="checkbox"/>	<input type="checkbox"/>			

4.b Vision Plan: Both the full time Kaiser HMO and the Kaiser Deductible plan include Kaiser vision coverage and are not eligible for VSP enrollment. All other medical plans (full or part-time), including the Kaiser part-time plans and Opt Out, are eligible for enrollment in VSP coverage. You must be enrolled in a medical plan or Opt out to enroll in VSP. Note: When you enroll for the Plus Plan, you pay a premium share percentage for Basic Plan coverage (e.g. 1%, 3%, 5% etc....) and the premium price difference between the Basic plan and the Plus Plan.

Enroll VSP Basic Plan –	<input type="checkbox"/>	Information on the VSP Basic and VSP Plus is available at: http://www.oregon.gov/oha/pebb/Benefits/Vision.pdf
Enroll VSP Plus - Includes the Basic Plan and PLUS additional benefits	<input type="checkbox"/>	
I Decline all VSP Enrollment	<input type="checkbox"/>	

4.c Medical Opt Out To enroll in Opt out you must attest at enrollment and each plan year thereafter to having an alternative minimum essential medical coverage. You do not need to provide proof of alternative medical coverage. See information at: <http://www.oregon.gov/oha/pebb/benefits/opt-out.pdf> Opt Out employees receive a monthly cash amount in lieu of enrollment in a PEBB medical plan. Full time employees will receive a taxable \$233 monthly, less \$1 for basic life. Part-time employee amounts are pro-rated.

Opting Out of a medical enrollment is conditioned upon my understanding and attesting that the following statements are true:

- I and all other individuals for whom I reasonably expect to claim a personal tax exemption deduction for have, or will have, an alternative medical coverage considered to be minimum essential coverage through an employer sponsored medical plan for the taxable year 2017. The following coverages are not eligible to Opt Out against: Oregon Health Plan/Medicaid, Veteran's Benefit Administration Programs, Student Health, and individual market coverage.
- I understand my employer will not pay the monthly opt-out payment to me if my employer knows or has reason to know that myself or any other member of my expected tax family does not have or will not have the alternative coverage.
- I understand that I must renew this attestation each plan year and applicable tax year for which I want the Opt Out to apply.

Enroll me in Opt Out.

By checking this box and signing the form (Section 11) I verify the above statements are true.

4.d Decline All PEBB Benefits

If you decline core benefits (medical/dental/vision/employee basic life), you're choosing to not participate in any of the PEBB programs. You will not receive cash in lieu of the medical coverage and you are not eligible to enroll in any PEBB plans.

5. Other Spousal/Partner Employer Group Coverage If you enroll in a medical plan and do not complete Section 5 a surcharge (\$50) will be deducted each month from your 2017 pay.

When your spouse or domestic partner **is enrolled in your PEBB medical coverage** and has access to medical coverage from their employer's sponsored group plan (i.e., a non- State of Oregon) but does not enroll for it, \$50 will be added to your monthly PEBB premium.

Check one box:

- My spouse/domestic partner has PEBB coverage as an eligible employee (Includes a spouse who enrolls in 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, but does not enroll in that coverage and is enrolled in PEBB coverage. (\$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)

6. Tobacco Use If you enroll in a Medical plan and do not complete Section 6 a tobacco surcharge (\$25.00 per employee and \$25.00 for spouse/partner enrolled in medical) will be deducted each month from your 2017 pay for PEBB coverage.

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 partners' provider advised not to quit using tobacco (Medical Waiver). (\$0)

7. Optional Life Insurances – Complete only the sections with changes. If there are no changes do not complete the sections.

7.a Dependent Life Insurance provides \$5,000 of coverage for each of your PEBB eligible dependent (including spouse or domestic partner). Medical history is **not** required. Premium rate is a total of \$1.29 per month. See information at:

<http://www.oregon.gov/oha/pebb/Pages/Dependent-Life.aspx>

Enroll for Coverage

Cancel Coverage

7.b Employee Optional Life Insurance Medical History Statement is required for a new enrollment or increases to existing coverage. Medical History Form (\$20,000 increments, maximum \$600,000). Rates and information at:

<http://www.oregon.gov/oha/pebb/Pages/Optional-Employee-Life.aspx>

Enroll or Increase Coverage

Cancel Coverage

Reduce Coverage to:

Your Current Amount

Additional Amount Requested
(Medical History Required)

Total Amount

\$ _____ +

\$ _____ =

\$ _____

Required: Tobacco use status, check one

I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)

I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

7. c Spouse or Domestic Partner Optional Life Insurance Medical History Statement required for a new enrollment or increases to existing coverage. Medical History Form (\$20,000 increments up to maximum of \$400,000). Rates and information at:

<http://www.oregon.gov/oha/pebb/Pages/Spouse-Partner-Life.aspx>

Enroll or Increase Coverage

Cancel Coverage

Reduce Coverage to:

Your Current Amount

Additional Amount Requested
(Medical History Required)

Total Amount

\$ _____ +

\$ _____ =

\$ _____

Required: Tobacco use status, check one

I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)

I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

8. Disability Insurance The benefits will replace a portion of salary when the employee has a qualified disability claim. **Complete only the sections with changes. If there are no changes do not complete the sections.**

8.a Short Term Disability The premium rate is 0.0064 times your gross monthly salary. Rates and information at:

<http://www.oregon.gov/oha/pebb/Pages/Short-Term-Disability.aspx>

Enroll for Coverage Cancel my Coverage

8.b Long Term Disability The monthly premium is determined by the rate (listed next to the plan) time your gross monthly salary. Rates and information at: <http://www.oregon.gov/oha/pebb/Pages/Long-Term-Disability.aspx>

<input type="checkbox"/> Enroll for Coverage (select one)	<input type="checkbox"/> Change my Coverage (select one)	<input type="checkbox"/> Cancel my Coverage
Waiting Periods – Coverage Level	<input type="checkbox"/> 90 days – 60% (.0051)	<input type="checkbox"/> 90 days – 66 2/3% (.0106)
	<input type="checkbox"/> 180 days – 60% (.0018)	<input type="checkbox"/> 180 days 66 2/3% (.0027)

9. Accidental Death Dismemberment (AD&D) Complete only if there is a change. Rates and information at: <http://www.oregon.gov/oha/pebb/Pages/ADD.aspx>

Cancel My Coverage

Employee only Coverage (premium = \$1 per \$50,000, \$50,000 increments, max \$500,000)

Total Coverage Amount \$_____

Employee & Dependent Coverage (premium = \$1.70 per \$50,000, \$50,000 increments, max \$500,000)

Total Coverage Amount \$_____

10. Beneficiary Designation Entity Key: I – Individual, W – Will, T = Living Trust. Total of primary percentages must = 100%. Total of contingent percentages must = 100% You can change your beneficiary designation yourself anytime during the year at <http://www.pebb.benefits.oregon.gov/members!/pb.main>

Standard Order of Survivorship (No beneficiary listed)

Designate the following as beneficiary. (List beneficiary)

Name	Relationship	Address	Entity	Primary	Contingent	Whole %
				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	

11. Employee Signature and Authorization If you elected to participate in the HEM program or the Medical Opt Out, your signature here indicates you agree to the terms of HEM agreement, or the Opt Out alternative coverage self-attestation.

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.

Employee Signature

Date

If you DO NOT want premiums deducted on a before tax basis, initial here_____.

Submit completed form to your agency payroll or university benefits office

Keep a copy of your benefit forms for your records.

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