PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Midyear Change

- Office use only -

Approved by: _____ Date:_____

Effective date:_____

See the Summary Plan Description for more information on benefits: www.oregon.gov/DAS/PEBB

1. Because I experienced a qualified midyear change, I want to:

☐ Add an individual to coverage ☐ Remove an individual from coverage (complete Section 5) ☐ Change my current plan enrollments

2. Contact information: **You must complete all fields. (**Please print)

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

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

3. Family coverage

List all eligible family members you want enrolled for 2016. Attach separate sheet if necessary. You cannot enroll a dependent child who will turn 27 in 2016.

Last name	First name	M	Birth date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
Spouse/domestic partner				☐ Spouse ☐ Domestic partner	☐ ☐	☐ ☐ ☐ **Cancel coverage** M ☐ D ☐ V ☐

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) is 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 your agency the enrollment form and affidavit.
- Adding a child by affidavit requires legal documentation, affidavit, and enrollment form. .
- If your partner or domestic partner's children are your federal tax dependents complete the Domestic Partner Certification for Dependent Tax Status and submit to your payroll.

Last name	First name	M	Birth date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
Child				{Select}	☐ ☐	☐ ☐ ☐ **Cancel coverage** **M** ☐ **D** ☐ **V** ☐

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				{Select}	☐ ☐	☐ ☐ ☐ **Cancel coverage** **M** ☐ **D** ☐ **V** ☐
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				{Select}	☐ ☐	☐ ☐ ☐ **Cancel coverage** **M** ☐ **D** ☐ **V** ☐
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. What changed in your life? (The event date must be included.)

See QSC Matrix at http://www.oregon.gov/DAS/PEBB in the Summary Plan Description

☐ Marriage	Date:	☐ Divorce or annulment	Date:
☐ Met eligibility for domestic partnership	Date:	☐ Termination of domestic partnership	Date:
☐ Birth	Date:	☐ Death of dependent or spouse	Date:
☐ Adoption or placement for adoption (legal documentation required)	Date:	☐ Dependent loses other medical group coverage	Date:
☐ Dependent gains other medical group coverage	Date:	☐ Employee gains other group coverage	Date:
☐ National Medical Support Notice (NMSN)	Date:	☐ Move out of current plan's service area	Date:
☐ Employment status change (describe):	Date:	☐ Loss of other group medical coverage	Date:
☐ Other reason (describe):			Date:

5. Did you terminate coverage for an individual?

Name and address for all dependents is required for COBRA notice.

Name	Address	City	State	Zip

6. Medical and dental plans (core benefits)

Full time employees may choose only from full time plans. Part time employees are eligible for part time or full time plans. Opt Out is a choice of medical plan.

Medical plans: Some plans have specific service areas and may not be available to you.
Dental: To enroll in dental you must be enrolled in a medical plan choice, Opt out medical plan choice enrollees can enroll in dental.
Vision plan: To enroll in VSP you must be enrolled in a medical plan choice. Kaiser HMO and the Kaiser Deductible plans have Kaiser Vision. Part-time and Opt Out medical plan choice enrollees can enroll for the VSP vision plan.

Medical: Check one box below for your 2016 medical plan.

	Full time	Part time
Kaiser Permanente HMO (Kaiser Vision)	☐	☐
Kaiser Deductible (Kaiser Vision)	☐	☐
Moda Summit	☐	☐
Moda Synergy	☐	☐
All Care PEBB	☐	☐
PEBB Statewide PPO	☐	☐
Providence Choice	☐	☐
Trillium	☐	☐

Dental: Check one box below for your 2016 dental plan.

	Full time	Part time
Kaiser Permanente	☐	☐
Moda Premier (ODS Traditional)	☐	☐
Moda PPO (ODS Preferred)	☐	N/A
Willamette Dental	☐	N/A

Waive enrollment in a dental plan: ☐ **Not enroll**

Vision (VSP): ☐ Enroll (You must be enrolled in a medical plan.) ☐ Not enroll

☐ **Medical Opt Out.** (Attach proof of your medical coverage along with this form.)

☐ **Decline All PEBB Benefits.** If you decline core benefits (medical/dental), you choose not to participate in the PEBB program. You will not receive cash in lieu of the medical coverage and you cannot enroll in any of the PEBB plans.

7. Other spousal/partner employer group coverage

When your spouse or domestic partner **is enrolled in your PEBB coverage** and also has access to coverage from their own employer's sponsored group plan (i.e. a non-Oregon-state-agency employer) and waives (does not enroll), the following amount will be deducted from your monthly pay for 2016 PEBB coverage: $50.00

Check one box:

- ☐ My spouse/domestic partner is a PEBB eligible employee and is enrolled in a PEBB medical plan (includes Opt Out).
- ☐ My spouse/domestic partner has other employer group coverage available and enrolls for that coverage and is also enrolled in PEBB plans.
- ☐ My spouse/domestic partner has other-employer group overage available, waives that coverage and is enrolled in PEBB. ($50)
- ☐ My spouse/domestic partner does not have other-employer group coverage available and is enrolled in a PEBB medical plan.
- ☐ I am not enrolling a spouse or domestic partner in a PEBB medical plan.
- ☐ I opt out of PEBB medical plans.

8. Tobacco use

When you or your spouse/domestic partner currently uses tobacco, the $25 per tobacco user will be deducted monthly from your pay for the 2016 plan year. An employee 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)
- ☐ My spouse/domestic partner and I currently use tobacco. ($50)
- ☐ My spouse/domestic partner and I currently do not use tobacco.
- ☐ 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.
- ☐ I opt out of PEBB medical plans.
- ☐ My or ☐ My spouse's or domestic partner's provider determined that a medical condition makes it unreasonably difficult to try to quit using tobacco.
- ☐ My or ☐ My spouse's or domestic partner's provider advised not to attempt to quit using tobacco.

9. Optional life insurance

(New or additional coverage above your current amount requires a medical history statement.)

Dependent Life Insurance $5,000 of coverage for each PEBB eligible dependent (including spouse or domestic partner). Medical history is **not** required. Premium rate is a $1.29 per month.

☐ Enroll for coverage ☐ Cancel coverage

Employee Optional Life Insurance ($20,000 increments, maximum $600,000). Medical History Statement required for amounts over the guarantee issue or for an increase. Table of calculated rates available at www.oregon.gov/DAS/PEBB under 2016 Benefit Link Life Insurance.

☐ Enroll or increase coverage	☐ Cancel coverage	☐ Reduce coverage to:
Newly eligible ONLY (Guarantee issue)	**Additional amount requested** (Medical History required)	**Total amount**
☐ $20,000 or ☐ $40,000 or ☐ $60,000 or ☐ $80,000 or ☐ $100,000	+ _____	= _____

Tobacco use status (you must 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.)

Spouse or Domestic Partner Optional Life Insurance ($20,000 increments, maximum $400,000). Medical History Statement required fo amounts over the guarantee issue or for an increase. Table of calculated rates available at: www.oregon.gov/DAS/PEBB under 2016 Benefit Link Life Insurance.

☐ Enroll or increase coverage	☐ Cancel coverage	☐ Reduce coverage to:
Newly eligible ONLY (Guarantee issue)	**Additional amount requested** (Medical History required)	**Total amount**
☐ $20,000 +	+ _____	= _____

Tobacco use status (you must check one)

☐ Spouse/domestic partner has used tobacco products in the previous 12 months. (Tobacco premium rates apply.)

☐ Spouse/domestic partner has not used tobacco products in the previous 12 months. (Non-tobacco premium rates apply.

10. Disability insurance

(Replaces a portion of salary when employee is eligible for the benefit.)

Short Term Disability The monthly premium rate is 0.0069 times your gross monthly salary **NOTE**: This plan is not available to seasonal or temporary employees.	
☐ Enroll for coverage	☐ Cancel coverage
Long Term Disability The monthly premium is determined by the rate (listed next to the plan) times your gross monthly salary. **NOTE**: This plan is not available to seasonal or temporary employees.	

☐ Enroll for coverage	☐ Change coverage to	☐ Cancel coverage
Waiting periods – coverage level (select one):		
☐ 90 days – 60% (.0051)	☐ 90 days – 66 2/3% (.0106)	
☐ 180 days – 60% (.0018)	☐ 180 days – 66 2/3% (.0027)	

11 Accidental Death and Dismemberment (AD&D)

☐ Employee only coverage (premium = $1 per $50,000)	Total coverage amount $_____ ($50,000 increments, max. $500,000)
☐ Employee & dependents coverage (premium = $1.70 per $50,000)	Total coverage amount $_____ ($50,000 increments, max. $500,000)

12. Beneficiary designation

☐ The Standard Order of Survivorship (no beneficiary listed)
☐ Designate the following as beneficiary:

Key: I = Individual, W = Will, T = Living Trust,
Total of primary percentages must = 100%
Total of contingent percentages must = 100%

Name	Relationship	Address	Entity	Primary	Contingent	Whole %
			☐ I ☐ W ☐ T	☐	☐	
			☐ I ☐ W ☐ T	☐	☐	
			☐ I ☐ W ☐ T	☐	☐	
			☐ I ☐ W ☐ T	☐	☐	
			☐ I ☐ W ☐ T	☐	☐	
			☐ I ☐ W ☐ T	☐	☐	

13. Employee 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.

_____ _____

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.