Public Employees' Benefit Board

Office use only
Approved by: ___________
Approved date: ___________
Effective date: ___________

Appeal Form

PEBB does not process insurance carrier appeals. If you disagree with a carrier decision, you must appeal directly to the insurance carrier. See your carrier's member handbook under **Benefits** at www.pebbinfo.com.

PEBB considers appeals on eligibility decisions, enrollment errors, omissions or missed enrollment time lines. See the Summary Plan Description under **Resources** at www.pebbinfo.com.

Contact information *(You must complete all fields.)*

PEBB benefit number (P########), OR#, University ID or Lottery ID

Last name	First name	Middle	Gender ☐ M ☐ F ☐ Other

☐ Check if new address

Contact address	Apartment #	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)

Your appeal

(Attach a separate sheet if necessary. Attach any supporting documentation for your appeal. If this appeal is regarding your HEM health assessment completion; attach your Health Assessment certificate of completion. Dates must be between September - October 31, 2019. HEM appeals will not be processed without the HEM certificate.)

1. Describe the problem.

2. Describe what you want PEBB to do.

Employee signature and authorization

I declare that the individuals listed on this 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 or submits false documents in connection with an application for any benefit may be subject to termination of enrollment, denial of future enrollment, civil damages, imprisonment and fines.
- If I fail to report 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.
- You must submit a midyear change form to your benefit office within 30 days of the date when an individual you provide coverage for is no longer PEBB eligible. If your notice is late, you and your qualified beneficiaries may lose the right to elect COBRA.
- This form supersedes all forms and submissions I previously made for PEBB coverage for individuals named.
- If you DO NOT want premiums deducted on a pre-tax basis, initial here._____

☐ I certify under penalty of Oregon State law that the foregoing is true and accurate to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.

Employee signature ____________________ Date ____________________

Keep a copy of benefit forms for your records.

Submit this form, any corrected enrollment forms and all supporting documentation to:

Public Employees' Benefit Board 500 Summer St NE, E89 Salem, OR 97301	**Email:** benefit.appeals@dhsoha.state.or.us **Fax:** 503-378-5832