pebb
Public Employees' Benefit Board

IRS Notice 2020-29 Midyear Change Form

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

Use this form to update your benefits no later than June 30, 2020. Forms received after this date will not be processed.

These plan elections or changes will go into effect the first of the month after this form is received.

Section 1: Employee information

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

Gender
◯ M ◯ F ◯ Other

Last name | First name | M.I.

Date of birth *(mm/dd/yyyy)*

☐ Check if new address

Address | Apartment or space#

City | State | ZIP | County

Work phone number | Cell phone number (Optional) | Email (Optional)

Are you Medicare eligible? ◯ Yes ◯ No

Are you serving or did you ever serve in the military? ◯ Yes ◯ No

If "Yes," do you authorize PEBB to send your name and address to the Oregon Department of Veterans' Affairs (ODVA) for the purpose of receiving benefit information? ◯ Yes ◯ No

Ethnicity *(Select one)*: ◯ Hispanic ◯ Non-Hispanic/Non-Latino ◯ Refused ◯ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary)*:

☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Section 2: IRS Notice 2020-29 change event *(check all that apply)*

A. Medical

☐ Add medical plan ☐ Add dependent(s) to medical plan ☐ Opt-out of medical

B. Dental

☐ Add dental plan ☐ Add dependent(s) to dental plan

C. Vision

☐ Add vision plan ☐ Add dependent(s) to vision plan

Section 3: Dependent information

1. List all eligible family members you want to terminate or provide coverage for. Attach additional dependent sheet if necessary.
2. **Required Affidavits and appropriate legal documents for a Domestic Partner, Child or Grandchild by Affidavit need to be submitted along with the enrollment form no later than 5 business days from the submittal of this enrollment form.** Find necessary affidavits under Forms at www.pebbinfo.com.
   - *Note: Payroll offices will not process enrollment for the individual until all documentation has been submitted.*
3. Please see Oregon Administrative Rule (101-015-0011) concerning eligible dependents by affidavit at: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=6
4. **If you are dropping medical coverage you MUST provide an address below for mailing of required COBRA notices.**

Dependent A **Enroll**: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic partner by Certificate ☐ Domestic partner by affidavit ☐ Child
☐ Step Child ☐ Partner's child ☐ Grandchild by affidavit (OAR 101-015-0011) ☐ Child by affidavit (OAR 101-015-0011)

Gender ○ M ○ F ○ Other

Date of birth *(mm/dd/yyyy)*

Medicare eligible? ☐ Y ☐ N

Last name First name Middle

Address *(if different from employee address)* City State ZIP

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*

☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent B

Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic partner by Certificate ☐ Domestic partner by affidavit ☐ Child
☐ Step Child ☐ Partner's child ☐ Grandchild by affidavit (OAR 101-015-0011) ☐ Child by affidavit (OAR 101-015-0011)

Gender ◯ M ◯ F ◯ Other | Date of birth *(mm/dd/yyyy)* | Medicare eligible? ◯ Y ◯ N

Last name | First name | Middle

Address *(if different from employee)* | City | State | ZIP

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent C

Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic partner by Certificate ☐ Domestic partner by affidavit ☐ Child
☐ Step Child ☐ Partner's child ☐ Grandchild by affidavit (OAR 101-015-0011) ☐ Child by affidavit (OAR 101-015-0011)

Gender ◯ M ◯ F ◯ Other | Date of birth *(mm/dd/yyyy)* | Medicare eligible? ◯ Y ◯ N

Last name | First name | Middle

Address *(if different from employee)* | City | State | ZIP

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent D

Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic partner by Certificate ☐ Domestic partner by affidavit ☐ Child
☐ Step Child ☐ Partner's child ☐ Grandchild by affidavit (OAR 101-015-0011) ☐ Child by affidavit (OAR 101-015-0011)

Gender ◯ M ◯ F ◯ Other | Date of birth *(mm/dd/yyyy)* | Medicare eligible? ◯ Y ◯ N

Last name | First name | Middle

Address *(if different from employee)* | City | State | ZIP

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Section 4: Healthcare plan selections

a: Choosing *not to* enroll in a PEBB medical plan, select one of the following options:

☐ **OPT-OUT**

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 have, or will have, an alternative medical coverage considered to be minimum essential coverage through an employer-sponsored medical plan for the taxable year 2020. You do not need to provide proof of alternative medical coverage. See information at http://www.oregon.gov/oha/pebb/documents/opt-out.pdf
  1. The following coverages are not eligible to Opt-Out against Oregon Health Plan/Medicaid, 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 I 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 Opt-Out agreement each plan year and applicable tax year for which I want the Opt-Out to apply.

By checking the Opt-Out box, and signing the form I verify the above statements are true.

b: Medical

If enrolled in a Moda medical plan, each covered individual must choose a PCP 360 for that individual to receive the "in-network" benefit. If an individual has not chosen a PCP 360 with Moda, they will receive the "out-of-network" level benefits. A list of PCP 360 providers can be found at: https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml

Medical plan selection:	Full-time	Part-time
Kaiser Deductible (Kaiser vision included with full time plan)	☐	☐
Kaiser Traditional (HMO) (Kaiser vision included with full time plan)	☐	☐
Moda Synergy	☐	☐
Providence (PEBB) Statewide	☐	☐
Providence Choice	☐	☐

Full-time employees may only enroll in full-time plans. Part-time employees can enroll in either full-time or part-time plans. If a part-time employee enrolls in full-time plan the part-time employee will not receive the part-time subsidy.

c: Dental plan selection:	Full-time	Part-time
Kaiser Permanente Dental	☐	☐
Delta Dental Premier	☐	☐
Delta Dental PPO	☐	N/A
Willamette Dental Group	☐	N/A

d: Vision plan selection:

◯ VSP Basic Plan

◯ VSP Plus — Includes the Basic Plan and PLUS additional benefits

Section 5: Tobacco usage

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

Check one box:

- ☐ I currently use tobacco, but my spouse/domestic partner currently does not use tobacco. ($25)
- ☐ I currently do not use tobacco, but 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 by 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)

Section 6: Other employer group coverage

When your spouse or Domestic Partner is enrolled in your PEBB medical coverage and has access to other group medical coverage (not a PEBB medical plan) from their employer's sponsored group plan, but does not enroll in it, $50 will be deducted from your monthly pay.

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, (not PEBB coverage) and enrolls for that coverage. ($0)
- ☐ My spouse/domestic partner has other employer group coverage available, (not PEBB coverage) 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)

Section 7: Employee signature and authorization

I declare the dependents listed and I are eligible for the coverages requested per Oregon Administrative Rule (OAR) Division 15. I have read the benefit materials, and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments to be deducted from my pay.

I understand that:

- 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.
- A person who knowingly makes a false statement in connection with an application for any benefit may be subject to penalty for false claims including, but not limited 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 payroll 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 have previously made regarding PEBB coverage for myself, and the individuals named above.

☐ I certify under penalty of Oregon State law that the information I have provided within this application is true and accurate to the best of my knowledge and belief.

Employee signature _____ Date _____

Submit this completed form to your agency/university payroll office.

Please keep a copy of benefit documents for your record