pebb
Public Employees' Benefit Board

Mid-year Change Form

Qualified Status Change (QSC)

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

See the Summary Plan Description and the QSC Matrix at www.pebbinfo.com.

Section 1: Employee Information

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

Gender
◯ M ◯ F ◯ Other

Last Name | First Name | Middle

Date of Birth (mm/dd/yyyy)

☐ **Check if new address**

Address | Apt or Unit

City | State | ZIP | County

Work Phone | Primary Phone | Email

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):

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

☐ White ☐ Other ☐ Refused ☐ Unknown

Section 2: What changed?

See the QSC Matrix at www.pebbinfo.com under Resources. The event date must be included below.
Dependent = Eligible Spouse, Domestic Partner, child(ren) or Grandchild(ren).

☐ Marriage	Date:
☐ Divorce or Annulment	Date:
☐ Addition of a Domestic Partnership (Include Domestic Partnership by Affidavit Form)	Date:
☐ Termination of Domestic Partnership	Date:
☐ Birth	Date:
☐ Adoption or Placement for Adoption (legal documentation required)	Date:
☐ Addition of a Child/Grandchild by Affidavit (Include appropriate PEBB Affidavit Form)	Date:
☐ Termination of a Child/Grandchild by Affidavit (Include appropriate PEBB Affidavit Form)	Date:
☐ Employee gains other group coverage	Date:
☐ Dependent gains other medical group coverage	Date:
☐ Employee loses other medical group coverage	Date:
☐ Dependent loses other medical group coverage	Date:
☐ Employment status change (describe)	Date:
☐ Death of a Dependent or Spouse	Date:
☐ National Medical Support Notice (NMSN)	Date:
☐ Moved out of current plan's services area	Date:
Tobacco midyear change info (Self): ☐ Quit ☐ Never used ☐ Medical provider advised not to quit (medical condition) ☐ Used tobacco in previous 12 months ☐ Have not used tobacco products in the previous 12 months	Date:
Tobacco midyear change info (Spouse/Domestic Partner): ☐ Quit ☐ Never used ☐ Medical provider advised not to quit (medical condition) ☐ Used tobacco in previous 12 months ☐ Have not used tobacco products in the previous 12 months	Date:

Section 3: Dependent Information

1. List all eligible family members you want to provide coverage for. Attach additional dependent sheets if necessary.
2. Required affidavits and legal documents for a Domestic Partner, Child, or Grandchild by Affidavit must be submitted no later than 5 business days from sumbitting this enrollment form.
    - Note: HR/Payroll offices will not begin benefits for these dependent(s) until all documenation has been given to HR/Payroll. Necessary affidavits are available at at www.pebbinfo.com.
3. Domestic Partner by Certificate does not require proof of certificate to HR/Payroll.
4. If you are terminating coverage for a dependent you MUST provide an address below for mailing of required COBRA notices. For more information, visit Oregon's Administrative Rule (101-015-0011) concerning eligible Dependents by Affidavit: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=6

Dependent A ☐ Terminate Coverage **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 | 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)
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent B ☐ Terminate Coverage **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 | 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)
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent C ☐ Terminate Coverage **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)
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent D ☐ Terminate Coverage **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)
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent E ☐ Terminate Coverage **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)
☐ 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:

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. You do not need to provide proof of alternative medical coverage. See information at: https://www.oregon.gov/oha/PEBB/Documents/Opt-out-Decline.pdf.
  - The following coverages are not eligible to Opt-Out against Oregon Health Plan/Medicaid, Student Health, and individual market coverage.

☐ **OPT-OUT**

- 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 attestation 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.

☐ **Decline** Select this option if you wish to 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.

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 recieve 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 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

☐ I decline dental enrollment

D: Vision Plan Selection:

- ☐ VSP Basic Plan
- ☐ VSP Plus — Includes the Basic Plan and PLUS additional benefits
- ☐ I decline VSP enrollment

Section 5: Double coverage surcharge

Are any of your covered family members offered medical insurance as an employee through OEBB or PEBB? ◯ Yes ◯ No

Are they enrolled in the OEBB or PEBB medical insurance offered? (If you answered yes to both questions, a $5 per month surcharge will be applied to your premium.) ◯ Yes ◯ No

Section 6: Tobacco usage

If you enroll in a Medical plan and do not complete this Section, a tobacco surcharge ($25 per employee and $25 for spouse/domestic 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 by 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 partner's provider advised not to quit using tobacco (Medical Waiver). ($0)

Section 7: 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 8: Optional plans

A: Optional Life Insurance

As a newly eligible employee for your first time enrollment, the Optional Employee Life has a guarantee issue enrollment amount of up to $100,000 and Optional Spouse/Domestic Partner Life has a guarantee issue enrollment amount of up to $20,000 without needing to submit a medical history to The Standard underwriting for approval.
You can find the Medical History Statement on the The Standard website at: https://www.standard.com/my-benefits/pebb

**Guarantee issue means medical history is not required. If an initial request is made with a Qualified Status Change (QSC), guarantee issue amount is applicable. You are required to submit a medical history statement on any coverage amount that is over guarantee issue.

Employee Optional Life Insurance

☐ Cancel coverage

Add or Reduce

New hire/Newly eligible enrollment $ _____ ($20,000 increments up to $100,000)

Additional requested amount above guarantee issue** $ _____ ($20,000 increments up to $500,000)

Total requested amount $ _____ ($600,000 maximum)

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.)

B: Spouse/Domestic Partner Optional Life Insurance

☐ Cancel coverage

Add or Reduce

New hire/Newly eligible enrollment $ _____ ($20,000)

Additional requested amount above guarantee issue** $ _____ ($20,000 increments up to $380,000)

Total requested amount $ _____ ($400,000 maximum)

Required: Tobacco use status, 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.)

C: Dependent Life Insurance

Provides $5,000 of coverage for each of your PEBB eligible dependent(s) (including spouse or domestic partner).
See rates at: www.pebbinfo.com

☐ Cancel coverage

☐ Enroll in coverage

D. Accidental Death & Dismemberment (AD&D) Insurance

☐ **Employee only** ☐ Cancel coverage

Total requested amount $_____ ($50,000 increments up to $500,000 maximum)

Medical history is not required.

Or

☐ **Employee and Dependent Optional AD&D** ☐ Cancel coverage

Total requested amount $_____ ($50,000 increments up to $500,000 maximum)

Medical history is not required.

E. Disability Insurance

Monthly premium is calculated on a percentage of your basic monthly salary. Benefits may replace a portion of salary when the employee has a qualified disability claim.

Short-Term Disability

Short-term disability plans pay weekly benefits with coverage dates depending upon plan enrollment.

☐ Enroll in coverage ☐ Cancel coverage

Long-Term Disability

Long-term disability plans pay monthly benefits starting after 90 or 180 day waiting period depending upon plan enrollment.

☐ Enroll or change coverage ☐ Cancel coverage

- ☐ After 90 day plan pays 60%
- ☐ After 90 day plan pays 66-2/3%
- ☐ After 180 day plan pays 60%
- ☐ After 180 day plan pays 66-2/3%

F. Long-term care insurance

To learn more about UNUM Long-Term Care (LTC) insurance, please visit:
https://www.oregon.gov/oha/pebb/Pages/Long-Term-Care.aspx

To enroll in UNUM Long-Term Care (LTC) insurance or to use the LTC premium calculator, please visit the UNUM webiste at: https://unuminfo.com/pebb/index.aspx

Section 9: Beneficiary Designation

I Elect:

☐ The Standard Order of Survivorship. (If you have a Domestic Partner, an Affidavit must be on file for distribution.)

☐ To designate the following Beneficiaries. (Attach additional sheets if necessary.)

Total of primary percentages must = 100% **Total of contingent percentages must = 100%**

Name			Address			
City	State	Zip	Relationship	Primary or contingent ☐ OR ☐	Whole % 0%	
Name			Address			
City	State	Zip	Relationship	Primary or contingent ☐ OR ☐	Whole % 0%	
Name			Address			
City	State	Zip	Relationship	Primary or contingent ☐ OR ☐	Whole % 0%	

Section 10: 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 payroll or university benefits office.

For contact information, please visit www.PEBBinfo.com

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