pebb
Public Employees' Benefit Board

Retiree Enrollment Form

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

See the Summary Plan Description for more information on benefits at www.pebbinfo.com.

Section 1: Enrollment type

☐ New Retiree (retirees have 30 days from the loss of active employee coverage to enroll in PEBB Retiree coverage)

Retirement Date:________________________

☐ Eligible by relationship to PEBB Retiree

PEBB Retiree name:____ Date of birth:________________________

☐ New retiree correcting enrollment elections

Section 2: Participant information

PEBB benefit number (P########)		Gender ☐ M ☐ F ☐ Other	Date of birth (mm/dd/yyyy)
Last name	First name		M.I.
Work phone number (optional)	Home phone number (optional)		Cell phone number (optional)
☐ Check if new address			
Address			Apartment or space#
City	State	ZIP	County
Personal email (optional)		Work email (optional)	

Are you Medicare eligible? ☐ Yes ☐ No

**Warning! All retirees and dependents of retirees lose eligibility for PEBB plans on the day they become eligible for Medicare due to age 65 or disability. Notify BenefitHelp Solutions immediately if you or your dependent is eligible for Medicare, regardless of whether you enroll in Medicare coverage.

Are you serving or have you ever served 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 3: Dependent information

1. List all eligible family members you want to provide coverage for. Attach additional dependent sheet if necessary.
2. Domestic Partner by Certificate does not require proof of certificate to HR/Payroll.

Dependent A Enroll ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Registered Domestic Partner ☐ 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 ☐ Registered Domestic Partner ☐ 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 C

Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Registered Domestic Partner ☐ 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 D

Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Registered Domestic Partner ☐ 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

Section 4: Healthcare plan selections

A: 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 Statewide	☐	☐
Providence Choice	☐	☐
☐ I decline medical enrollment (If you decline it can not be added back in the future.)		

B: Dental plan selection:	Full-time	Part-time
Kaiser Permanente	☐	☐
Delta Dental Premier	☐	☐
Delta Dental PPO	☐	N/A
Willamette Dental Group	☐	N/A
☐ I decline dental enrollment. (If you decline it can not be added back in the future.)		

C: Vision plan selection:
☐ VSP Basic Plan
☐ VSP Plus — Includes the Basic Plan and PLUS additional benefits
☐ I decline VSP enrollment. (If you decline it can not be added back in the future.)

Section 5: 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/ partner enrolled in medical) will be added each month to your benefit amount due.

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 partner's 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 added each month to your benefit amount due.

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, such as OEBB, and enrolls for that coverage.($0)

☐ My spouse/domestic partner has other employer group overage available, such as OEBB, 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: Participant signature and authorization

I declare the dependents listed here 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.

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 or submits false documents 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 new Midyear Change Form 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 dependents 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.

Participant signature ______________________ Date ____________

Submit completed form to: (Always keep copies for your records.)

BenefitHelp Solutions PO Box 40548, Portland, OR 97240	or by fax: 503-765-3453 or 1-888-393-2943