

SB 551 Member Enrollment

Office use only

Approved by: _____

Approved date: _____

Effective date: _____

Member information

Last name		First name		Middle
PEBB# (P#####) or University ID#/OR#		Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other		Date of birth (mm/dd/yyyy)
Home phone number		Work phone number		Cell phone number
Personal email		Work email		
Address <input type="checkbox"/> Check if new address		Apartment or space#		
City	State	ZIP	County	
Are you Medicare eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you serving or did you ever serve in the military? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Ethnicity (Select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown				
Race (Select at least one. If selecting more than one, circle one as primary): <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Refused <input type="checkbox"/> Unknown				

Medical plans

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:

Kaiser Deductible (Kaiser vision included with full-time plan)	<input type="checkbox"/>
Kaiser Traditional (HMO) (Kaiser vision included with full-time plan)	<input type="checkbox"/>
Moda Synergy	<input type="checkbox"/>
Providence Statewide	<input type="checkbox"/>
Providence Choice	<input type="checkbox"/>

Dental plan selection:

Kaiser Permanente	<input type="checkbox"/>
Delta Dental Premier	<input type="checkbox"/>
Delta Dental PPO	<input type="checkbox"/>
Willamette Dental Group	<input type="checkbox"/>

☐ I decline dental enrollment

Vision plan selection:

<input type="checkbox"/> VSP Basic Plan
<input type="checkbox"/> VSP Plus — Includes the Basic Plan and PLUS additional benefits
<input type="checkbox"/> I decline VSP enrollment

Member signature and authorization

I understand that these benefit elections will remain in effect for as long as I continue to meet the SB 551 eligibility or participation requirements as determined by my selected Home Institution.

I have read and understand OAR-Division 15, Sections 101-015-0030, 101-015-0035, and 101-015-0040 concerning Eligibility and Policy Term Violations and can find this OAR at: <https://go.usa.gov/xMDeV>

I understand I have 31 days to notify my Home Institution of a Qualified Status Change (QSC) which affects eligibility. A full list of QSC's can be found at: <https://www.oregon.gov/oha/PEBB/Documents/AppendixA-QSC.pdf>

I have read and understand OAR-Division 20 concerning Enrollment and can find this OAR at: <https://go.usa.gov/xMDeG>

I have read the benefit materials and I understand the limitations and qualifications of the SB 551 benefits program.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

This election supersedes all elections and submissions I previously made for SB 551 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 perjury.

Member signature

Date

Submit this form to your University Payroll/Benefits Office for SB 551 Coverage:

DO NOT SUBMIT TO PEBB