pebb
Public Employees' Benefit Board

2021–22 Plan Year
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 ☐ M ☐ F ☐ Other	Date of birth *(mm/dd/yyyy)*
Home phone number	Work phone number	Cell phone number
Personal email	Work email	
Address ☐ Check if new address		Apartment or space#
City	State / ZIP	County

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

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)	☐
Kaiser Traditional (HMO) (Kaiser vision included with full-time plan)	☐
Moda Synergy	☐
Providence (PEBB) Statewide	☐
Providence Choice	☐

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