pebb
Public Employees' Benefit Board

Self-Pay Enrollment and Correction

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 participant eligibility date: _____

☐ Correction to new participant enrollment.

- Complete only the sections that relate to your error. Be sure to sign and date the form.

Check one:

☐ OLCC Agent ☐ Post Doc/J1Visa ☐ Blind Business Enterprise

☐ Foster Parent (attach copy of Foster Parent Certificate) ☐ Nurse working less than half time

Section 2: Participant information

PEBB benefit number (P########)	Gender ☐ M ☐ F ☐ Other	Date of birth *(mm/dd/yyyy)*
Last name	First name	M.I.
Home phone number (optional)	Cell phone number (Optional)	

☐ Check if new address

Address	Apartment or space#
City	State ZIP County
Personal email (Optional)	

Are you Medicare eligible? ☐ Yes ☐ No

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 terminate or provide coverage for. Attach additional dependent sheet if necessary.

2. Required affidavits and appropriate **legal documents for eligible dependents by affidavit must 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.*
   - *BenefitHelp Solutions will not process enrollment for individuals until all documentation has been submitted.*
   - *See Oregon Administrative Rule (101-015-0011) concerning eligible dependents by affidavit at:* https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=6

Dependent A ☐ Terminate coverage 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 ☐ Terminate coverage 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 ☐ Terminate coverage 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 ☐ Terminate coverage 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:	
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	☐
You must select a Medical plan to be eligible for Dental and Vision	

B: Dental plan selection:	
Kaiser Permanente	☐
Delta Premier	☐
Delta PPO	☐
Willamette Dental Group	☐
☐ I decline dental enrollment.	

C: Vision plan selection:
☐ VSP Basic Plan
☐ VSP Plus — Includes the Basic Plan and Plus additional benefits
☐ I decline VSP enrollment.

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 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.
- ☐ Me 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 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: 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 statements 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 BenefitHelp Solutions within 30 days of an individual you provide coverage for no longer meeting PEBB eligibility requirements. 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