pebb
Public Employees' Benefit Board

Unum Long-Term Care (LTC) Enrollment or Cancellation Form

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

See the Summary Plan Description for more information on benefits at www.oregon.gov/OHA/PEBB. Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/pebb.

Employee Information (you must complete all fields)

Group policy number 025758	Agency name (ex. Oregon Health Authority)	Agency number (5-digit agency code)
PEBB benefit number (P#)		Hire Date
Last name	First name	MI
Date of birth (mm/dd/yyyy)		Gender ◯ M ◯ F ◯ Other

☐ Check if new address

Contact address	Apartment #	City	State	ZIP
Phone number	Email address			

Coverage Information — Applicant is:

☐ Employee ☐ Spouse ☐ Domestic Partner

Applicant Information (You must complete all fields)

Last name	First name	MI
Date of birth (mm/dd/yyyy)		Gender ◯ M ◯ F ◯ Other
Phone number	Email address	

Premiums can be found at: www.unuminfo.com/pebb/calculator.aspx

Enrollment Reason:

☐ Newly Hired Employee	☐ Midyear Change
☐ Open Enrollment	☐ Cancel (Skip to signature line)
☐ Correction	

Facility Benefit Duration (check one):

☐ 3 years	☐ 6 Years	☐ Unlimited Duration

Facility Monthly Benefit Amount (check one):

☐ $1,000	☐ $2,000	☐ $3,000
☐ $4,000	☐ $5,000	☐ $6,000

Newly Hired Employees

Will have 30 days from date of hire to sign up for guarantee issue coverage. Coverage is effective the first of the month following the date your form is received by PEBB. As a new hire you are eligible for benefit amounts on a guarantee issue basis of up to and including $4,000 and a duration of 3 or 6 years. Spouses and Domestic Partners can also enroll and require a medical questionnaire for all coverages.

Current Employees

Current employees can enroll at any time, not just during Open Enrollment. All coverages will be subject to approval of a medical questionnaire, which will need to be sent directly to Unum. Spouses and Domestic Partners can also enroll and require a medical questionnaire for all coverages.

Cancellations

Coverage will end the first of the month following the date of receipt of this signed and dated form.

Plans (check one):

☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4
• Long-Term Care Facility • Professional Home Care	• Long-Term Care Facility • Professional Home Care • Total Home Care	• Long-Term Care Facility • Professional Home Care • Simple inflation Uncapped	• Long-Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation Uncapped

Signature and authorization

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand 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. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program.

I understand that:

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

**Caution: If your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny or rescind your insurance.

If you are an **Active Employee, Spouse or Domestic Partner**: your premium will be paid through the employee's payroll deduction. Employee must sign below to authorize the employer to make the payroll deduction.

This form supersedes all forms and submissions I previously made for Unum LTC 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 false claims.

You also acknowledge that you have reviewed the Potential Rate Increase Disclosure Form and Personal Worksheet which can be found at www.unuminfo.com/pebb

By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this LTC plan in order to be covered, and that certain limitations and exclusions apply to your coverage.

_____ _____

Employee Signature (required for Spouse/Domestic Partner coverage) Date

_____ _____

Applicant's Signature (if different from employee) Date

Any alteration of this form may result in it being ineffective.

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

Send your Evidence of Insurability - Medical Questionnaire directly to Unum.

Due to HIPAA, any copies received by PEBB will be shredded.

http://unuminfo.com/pebb/enrollment.aspx.

Send only this form to:	
by mail: PEBB Member Services 500 Summer Street NE, E-89 Salem, OR 97301-1063	**or by fax:** 503-373-1654 **or by email:** pebb.benefits@odhsoha.oregon.gov