pebb
Public Employees' Benefit Board

Appeal Form

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

PEBB does not process insurance carrier appeals. If you disagree with a carrier decision, you must appeal directly to the insurance carrier. See your carrier's member handbook under **Benefits Information** at: www.pebbinfo.com.

PEBB considers appeals on eligibility decisions, enrollment errors, omissions or missed enrollment time lines. See the Summary Plan Description under **Resources** at www.pebbinfo.com.

Contact Information (You must complete all fields.)

PEBB Benefit Number (P+8 Numbers), Employee ID (OR+7 Numbers), University ID or Lottery ID

Last Name | First Name | Middle Name | Gender ☐ M ☐ F ☐ Other

☐ **Check if new address**

Street Address | Apartment or Unit | City | State | ZIP

Work ZIP Code | Work Email | Personal Email

Date of Birth (mm/dd/yyyy) | Work Phone Number | Preferred Contact Number:

Your Appeal

(Attach a separate sheet if necessary. Attach any supporting documentation for your appeal.)

Please describe the problem.

Describe what you want PEBB to do.

Employee Signature and Authorization

I declare that the individuals listed on this 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. If necessary, I authorize premium payments deducted from my pay.

I understand that:

- A person who knowingly makes a false statement or submits false documents in connection with an application for any benefit may be subject 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 your agency payroll or university benefits office within 30 days of any dependent you provide coverage for but is no longer PEBB eligible. If your form is late, you and any remaining qualified dependents might lose the right to elect COBRA.
- This form supersedes all forms and submissions I previously made for PEBB coverage for individuals named.

➢ **If** you DO NOT want premiums deducted on a pre-tax basis, initial here. _____

☐ I certify under penalty of Oregon State law that the foregoing is true and accurate to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.

_____ _____

Employee Signature Date

Submit this form, any corrected Enrollment Forms and all supporting documentation to:

Mail: Public Employees' Benefit Board
500 Summer St NE E89
Salem, OR 97301

Email: benefit.appeals@odhsoha.oregon.gov

Secure fax: 503-378-5832

Please, keep a copy for your records.