pebb
Public Employees' Benefit Board

Surcharges Mid-Year Change Form

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

See the Summary Plan Description and the QSC Matrix at www.pebbinfo.com.

Section 1: Employee information

PEBB benefit number (P########), OR#, University ID or Lottery ID

Gender
◯ M ◯ F ◯ Other

Last name | First name | Middle name or initial

Date of birth (mm/dd/yyyy)

☐ **Check the box if this is a new address**

Address | Apt or Unit

City | State | ZIP | County

Work Phone | Home Phone | Email

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):

☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Section 2: What changed?

See the QSC Matrix at www.pebbinfo.com under Resources. The event date must be included below.
Dependent = Eligible Spouse, Domestic Partner, or Child.

☐ Employee gains other group coverage	Date:
☐ Dependent gains other medical group coverage	Date:
☐ Employee loses other medical group coverage	Date:
☐ Dependent loses other medical group coverage	Date:
Tobacco midyear change info (Self): ☐ Quit ☐ Never used ☐ Medical provider advised not to quit (medical condition) ☐ Used tobacco in previous 12 months ☐ Have not used tobacco products in the previous 12 months	Date:
Tobacco midyear change info (Spouse/Domestic Partner): ☐ Quit ☐ Never used ☐ Medical provider advised not to quit (medical condition) ☐ Used tobacco in previous 12 months ☐ Have not used tobacco products in the previous 12 months	Date:

Section 3: Double coverage surcharge

Are any of your covered family members offered medical insurance as an employee through OEBB or PEBB? ◯ Yes ◯ No

Are they enrolled in the OEBB or PEBB medical insurance offered? (If you answered yes to both questions, a $5 per month surcharge will be applied to your premium.) ◯ Yes ◯ No

Section 4: Tobacco usage

If you enroll in a Medical plan and do not complete this Section, a tobacco surcharge ($25 per employee and $25 for spouse/domestic partner enrolled in medical) will be deducted each month from your pay.

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 by 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.
- ☐ My or ☐ My spouse's or domestic partner's provider advised not to quit using tobacco (Medical Waiver). ($0)

Section 5: 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 deducted from your monthly pay.

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, (not PEBB coverage) and enrolls for that coverage. ($0)
- ☐ My spouse/domestic partner has other employer group coverage available, (not PEBB coverage) 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 6: 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 statement 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 your payroll office within 30 days of the date when an individual you provide coverage for is no longer PEBB eligible. If your notice is late, you and your qualified beneficiaries 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.

Employee signature _____ Date _____

Submit this completed form to PEBB or your agency payroll/university benefits office. Please keep a copy for your records.

For contact information, please visit www.PEBBinfo.com.