PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Transfer of Premium Payment

Life & Long Term Care Insurance

- Office Use Only -

Approved by ___ Date___

Effective Date_____

See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml

Submit completed form to your agency payroll or university benefits office.

1. I want to move these premium payments because of

☐ **Retirement** ☐ **Job Termination** ☐ **Divorce or Termination of Domestic Partnership**

☐ **Military Leave** ☐ **Returning to work within 12 months**

2. Life Insurance Action

☐ Move Insurance premiums payments to me from spouse or domestic partner

☐ Continue at Current Coverage Amount	☐ Reduce Coverage Amount to $_____

3. Long Term Care Insurance Action

☐ Move Long Term Care Insurance premiums payments to me from spouse

☐ Continue at Current Coverage Amount	☐ Reduce Coverage Amount to $_____

4. Your Information (Person who will start paying premiums)

Last Name	First Name	MI	Agency #	Gender ○ F ○ M

PEBB Benefit Number (P########), Employee ID, University ID	Date of Birth _ _ / _ _ / _ _ _ _

Contact Address ☐ Check if New Address	Apt #	City	State	Zip	County

Work E-mail	Work Phone ( ) -

5. Your Authorization

I understand the elections I made are in effect, pending approval by The Standard Insurance Company or UnumProvident (if required) and as long as eligibility requirements are met, until I elect to change the elections, subject to the provisions of each plan. Benefit costs will be taken out of my pay by monthly payroll deduction. I have read the benefit materials and understand the limitations and qualifications of the PEBB Benefit Program.

_____ _____

Your Signature Date

6. Your Spouse's or Domestic Partner's Information (Person who will stop paying premiums)

Last Name	First Name	MI	Agency #	Gender
				☐ F ☐ M

PEBB Benefit Number (P########), Employee ID, University ID	Date of Birth
	_ _ / _ _ / _ _ _ _

Contact Address ☐ Check if New Address Apt # City State Zip County

Work E-mail	Work Phone
	( ) -

7. Your Spouse's or Domestic Partner's Authorization

I authorize the release of information regarding my optional life plan coverage or long term care plan enrollment to the above named subscriber. I authorize the use of this information only as needed to complete the request for roll over of premium payment for these benefits.

_____ _____

Spouse's or Domestic Partner's Signature Date

Submit completed form to your agency payroll or university benefits office.

Keep a copy of all benefit documents for your records.

Print Form