



# 2019 New Employee Enrollment

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](http://www.oregon.gov/OHA/PEBB). **Submit completed form to your agency payroll or university benefits office. Keep a copy of your benefit forms for your records. Any alteration of this form may result in it being ineffective.**

## I am enrolling as

☐ Newly eligible employee ☐ Newly eligible employee correcting enrollment elections

## Contact information *(You must complete all fields)*

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

Last name	First name	Middle	Agency	Gender
				<input type="checkbox"/> M <input type="checkbox"/> F

Contact address	<input type="checkbox"/> Check if new address	Apartment #	City	State	ZIP

Residence ZIP code	Work ZIP code	Work email	Personal email (optional)

Date of birth (mm/dd/yyyy)	Work phone	Home phone (optional)

Are you Medicare eligible? (This will not affect enrollment) ☐ No ☐ Yes

Are you serving or did you ever serve in the military? ☐ No ☐ Yes

Do you authorize PEBB to send your name and address to Oregon Department of Veteran's affairs (ODVA) for the purpose of receiving benefit information? ☐ No ☐ Yes

Ethnicity: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Unknown ☐ Refuse

Race: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown ☐ Refuse ☐ Other

## Family coverage

*(List all eligible family members you want to provide coverage for. Attach additional dependent sheet if necessary.)*

Spouse/Domestic Partner Last name	First name	Middle	Birth date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
				<input type="checkbox"/> Spouse <input type="checkbox"/> Partner	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Address: Complete only if different

Is this dependent Medicare eligible? (This will not affect enrollment) ☐ No ☐ Yes

Ethnicity: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Unknown ☐ Refuse

Race: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American  
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown ☐ Refuse ☐ Other

## If you listed a Domestic Partner, mark the type of Domestic Partnership

☐ **Registered Certificate of Domestic Partnership** (Copy not required) You have a registered certificate issued to you and your same sex partner by an Oregon county clerk.

☐ **PEBB Domestic Partner Affidavit** is a partnership between an eligible employee and an individual of the opposite sex, or same sex without a Certificate of Registered Domestic Partnership.

**Affidavits need to be submitted along with the enrollment form. Note: Payroll/Benefit offices will not process the enrollment for the individual until all documentation has been submitted.**

## Eligible dependent children

*(List the eligible children you want to provide coverage for. Attach a separate sheet if necessary.)*

**Required affidavits and appropriate legal documents for child by affidavit or grandchild need to be submitted along with the enrollment form. Note: Payroll/Benefit offices will not process the enrollment for the individual until all documentation has been submitted.**

Child — Last name	First name	Middle	Birth date mm/dd/yyyy	Gender M F	Enroll Med Den Vision
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Dependent Status ☐ Child ☐ Partner's child ☐ Grandchild by affidavit (both parent and grandchild are required to be living with you)  
☐ Step Child ☐ Child by affidavit (includes, but not limited to: foster child and child placed for adoption or grandchild. When adoption is final provide paperwork to your payroll/HR to have status changed to child)

Address: Complete only if different

Is this dependent Medicare eligible? (This will not affect enrollment) ☐ No ☐ Yes

Ethnicity: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Unknown ☐ Refuse

Race: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American  
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown ☐ Refuse ☐ Other

Child — Last name	First name	Middle	Birth date mm/dd/yyyy	Gender M F	Enroll Med Den Vision
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dependent Status <input type="checkbox"/> Child <input type="checkbox"/> Partner's child <input type="checkbox"/> Grandchild by affidavit (both parent and grandchild are required to be living with you) <input type="checkbox"/> Step Child <input type="checkbox"/> Child by affidavit (includes, but not limited to: foster child and child placed for adoption or grandchild. When adoption is final provide paperwork to your payroll/HR to have status changed to child)					
Address: Complete only if different					
Is this dependent Medicare eligible? (This will not affect enrollment) <input type="checkbox"/> No <input type="checkbox"/> Yes					
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse					
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse <input type="checkbox"/> Other					

  

Child — Last name	First name	Middle	Birth date mm/dd/yyyy	Gender M F	Enroll Med Den Vision
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dependent Status <input type="checkbox"/> Child <input type="checkbox"/> Partner's child <input type="checkbox"/> Grandchild by affidavit (both parent and grandchild are required to be living with you) <input type="checkbox"/> Step Child <input type="checkbox"/> Child by affidavit (includes, but not limited to: foster child and child placed for adoption or grandchild. When adoption is final provide paperwork to your payroll/HR to have status changed to child)					
Address: Complete only if different					
Is this dependent Medicare eligible? (This will not affect enrollment)? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse					
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse <input type="checkbox"/> Other					

  

Child — Last name	First name	Middle	Birth date mm/dd/yyyy	Gender M F	Enroll Med Den Vision
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dependent Status <input type="checkbox"/> Child <input type="checkbox"/> Partner's child <input type="checkbox"/> Grandchild by affidavit (both parent and grandchild are required to be living with you) <input type="checkbox"/> Step Child <input type="checkbox"/> Child by affidavit (includes, but not limited to: foster child and child placed for adoption or grandchild. When adoption is final provide paperwork to your payroll/HR to have status changed to child)					
Address: Complete only if different					
Is this dependent Medicare eligible? (This will not affect enrollment) <input type="checkbox"/> No <input type="checkbox"/> Yes					

Ethnicity:	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Unknown	<input type="checkbox"/> Refuse
Race:	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Black/African American	<input type="checkbox"/> White
	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Unknown	<input type="checkbox"/> Refuse	<input type="checkbox"/> Other

## ☐ Decline all PEBB benefits

If you decline core benefits (medical/dental/vision/employee basic life), you're choosing to not participate in any of the PEBB programs. You will not receive cash in lieu of the medical coverage and you are not eligible to enroll in any PEBB plans.

## Medical plans/Dental plans

*(Some plans have specific service areas and may not be available to you, be sure to review plan availability for your area.)*

Medical Opt Out To enroll in Opt out you must attest at enrollment and each plan year thereafter to having an alternative minimum essential medical coverage. You do not need to provide proof of alternative medical coverage. See information at: <http://www.oregon.gov/oha/pebb/benefits/opt-out.pdf>

Opting Out of a medical enrollment is conditioned upon my understanding and attesting that the following statements are true:

- I and all other individuals for whom I reasonably expect to claim a personal tax exemption deduction for have, or will have, an alternative medical coverage considered to be minimum essential coverage through an employer sponsored medical plan for the taxable year 2019. The following coverages are not eligible to Opt Out against: Oregon Health Plan/Medicaid, Veteran's Benefit Administration Programs, Student Health, and individual market coverage.
- I understand my employer will not pay the monthly opt-out payment to me if my employer knows or has reason to know that myself or any other member of my expected tax family does not have or will not have the alternative coverage.
- I understand that I must renew this attestation each plan year and applicable tax year for which I want the Opt Out to apply.

☐ **Enroll me in Opt Out. By checking this box and signing the form I verify the above statements are true.**

Medical	Full-time	Part-time	Dental	Full-time	Part-time
Kaiser Deductible (Kaiser vision included with full-time plan)	<input type="checkbox"/>	<input type="checkbox"/>	Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser HMO (Kaiser vision included with full-time plan)	<input type="checkbox"/>	<input type="checkbox"/>	Delta Premier	<input type="checkbox"/>	<input type="checkbox"/>
Moda Summit	<input type="checkbox"/>	<input type="checkbox"/>	Delta PPO	<input type="checkbox"/>	N/A
Moda Synergy	<input type="checkbox"/>	<input type="checkbox"/>	Willamette Dental	<input type="checkbox"/>	N/A
PEBB Statewide PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I Decline all Dental Plan Enrollment		
Providence Choice	<input type="checkbox"/>	<input type="checkbox"/>			

Full-time employees can only enroll in full-time plans. Part-time employees can enroll in either full-time or part-time plans. If a part-time employee enrolls in full-time plans, the part-time employee will not receive the part-time subsidy.

## Vision plan

☐ Enroll VSP Basic Plan

☐ Enroll VSP Plus — Includes the Basic Plan and PLUS additional benefits

☐ I Decline all VSP Enrollment

## Optional life insurances *(Complete only the sections required for enrollment.)*

### Employee optional life insurance

*(Medical History Statement is required for any amount over the guarantee issue. See rates at [www.oregon.gov/OHA/PEBB](http://www.oregon.gov/OHA/PEBB))*

(\$20,000 increments, with a maximum of \$600,000)

☐ Enroll or increase coverage

☐ Cancel coverage

☐ Reduce coverage to:

**Newly eligible ONLY (Guarantee issue)**

☐ \$20,000    ☐ \$40,000    ☐ \$60,000

☐ \$80,000    ☐ \$100,000 +

**Additional amount requested**  
(Medical history required)

\$ \_\_\_\_\_ =

**Total amount**

\$ \_\_\_\_\_

### Required: Tobacco use status, check one

☐ I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)

☐ I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

### Spouse or Domestic Partner Optional Life Insurance

*(Medical History Statement is required for any amount over the guarantee issue. See rates at [www.oregon.gov/OHA/PEBB](http://www.oregon.gov/OHA/PEBB))*

(\$20,000 increments up to maximum of \$400,000)

☐ Enroll or increase coverage

☐ Cancel coverage

☐ Reduce coverage to:

**Newly eligible ONLY (Guarantee issue)**

☐ \$20,000 +

**Additional amount requested**  
(Medical history required)

\$ \_\_\_\_\_ = \_\_\_\_\_

**Total amount**

\$ \_\_\_\_\_

### Required: Tobacco use status, check one

☐ I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)

☐ I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

If medical history statement is required, please submit to The Standard within 90 days of enrollment or amounts above guarantee issue will be canceled. \$100,000 is the maximum guarantee issue. Enrollment above \$100,000 will require additional medical evidence.

**Dependent life insurance provides \$5,000 of coverage for each of your PEBB eligible dependent (including spouse or domestic partner)** See rates at [www.oregon.gov/OHA/PEBB](http://www.oregon.gov/OHA/PEBB)

☐ Enroll in coverage

☐ Cancel coverage

**Accidental death & dismemberment (AD&D)** (see rates at [www.oregon.gov/OHA/PEBB](http://www.oregon.gov/OHA/PEBB))☐ Enroll in coverage      ☐ Cancel coverage      ☐ Change coverage☐ Employee only coverage

Total coverage amount \$ \_\_\_\_\_

☐ Employee & Dependent Coverage

Total coverage amount \$ \_\_\_\_\_

**Disability insurance** *The benefits will replace a portion of salary when the employee has a qualified disability claim. (See rates at [www.oregon.gov/OHA/PEBB](http://www.oregon.gov/OHA/PEBB))***Long term disability**☐ Enroll in coverage☐ 90 days – 60%☐ 90 days – 66 2/3%☐ 180 days – 60%☐ 180 days – 66 2/3%☐ Change coverage (select one)☐ 90 days – 60%☐ 90 days – 66 2/3%☐ 180 days – 60%☐ 180 days – 66 2/3%☐ Cancel coverage**Short term disability**☐ Enroll in coverage☐ Cancel coverage**Tobacco use***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 deducted each month from your pay.***Check one box:**☐ I currently use tobacco and, my spouse/domestic partner currently does not use tobacco. (\$25)☐ I currently do not use tobacco, and 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 in PEBB. (\$0)☐ I do not enroll in PEBB medical plans.☐ My or ☐ My spouse's or domestic partners' provider advised not to quit using tobacco (Medical Waiver). (\$0)

## Other spouse/partner employer group coverage

*If you enroll in a medical plan and cover a spouse or partner you need to complete this section or a surcharge will be deducted each month from your pay.*

When your spouse or domestic partner is enrolled in your PEBB medical coverage and has access to medical coverage from their employer's sponsored group plan (i.e., a non-State of Oregon) but does not enroll in it, \$50.00 will be deducted each month from your 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 available and enrolls for that coverage. (\$0)
- ☐ My spouse/domestic partner has other-employer group coverage available, 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)

## Beneficiary designation

*Total of primary and contingent percentages must = 100%. You can change your beneficiary designation yourself anytime during the year at [https://pebbbenefits.oha.oregon.gov/bms\\_web!/pb.main](https://pebbbenefits.oha.oregon.gov/bms_web!/pb.main)*

- ☐ Standard order of survivorship (No beneficiary listed)    ☐ Designate the following as beneficiary (List beneficiary)

Name	Relationship	Address	Entity	Primary	Contingent	Whole %
			<input type="checkbox"/> Individual <input type="checkbox"/> Trust <input type="checkbox"/> Will	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> Individual <input type="checkbox"/> Trust <input type="checkbox"/> Will	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> Individual <input type="checkbox"/> Trust <input type="checkbox"/> Will	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> Individual <input type="checkbox"/> Trust <input type="checkbox"/> Will	<input type="checkbox"/>	<input type="checkbox"/>	

**Note:** A change in beneficiary will revoke any previous selections.

**Employee signature and authorization** *(If you elected the Medical Opt Out, your signature indicates you agree to the terms of the Opt Out alternative coverage self-attestation.)*

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 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.
  - 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 benefit 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 previously made for PEBB coverage for individuals named.
- ☐ I certify under penalty of the State of Oregon laws that the foregoing is true and accurate to the best of my knowledge and belief. I declare the dependents listed and I are eligible for the coverages requested per PEBB Administrative Rule (OAR) Division 15. I understand that they are subject to penalty for false claims.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date