Transfer of Premium Payment

The Standard Optional Life and UNUM Long-Term Care Insurance

Office use only
Approved by: ___________________
Approved date:__________________
Effective date: __________________

See the Summary Plan Description for more information: www.pebbinfo.com

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

☐ Date of Event ______________________________

Optional life insurance action

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

☐ Continue at current coverage amount ☐ Reduce Coverage Amount to $______

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 $_____

Your information (Person who will start paying premiums)

PEBB benefit number (P########), OR#, University ID or Lottery ID						Date of birth (mm/dd/yyyy)
Last name	First name	M.I.				Gender ☐ M ☐ F ☐ Other
Contact address ☐ Check if new address	Apartment #	City	State	ZIP		County
Work email						Work phone

MSC 5551 (09/2023)

Your authorization

☐ I understand the elections I made are in effect 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 ______________

Your spouse's or domestic partner's information (Person who will stop paying premiums)

PEBB benefit number (P########), OR#, University ID or Lottery ID						Date of birth (mm/dd/yyyy)
Last name	First name		M.I.		Gender ☐ M ☐ F ☐ Other	
Contact address	☐ Check if new address	Apartment #	City	State	ZIP	County
Work email					Work phone	

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 your benefit forms for your records.