pebb
Public Employees' Benefit Board

Midyear Change Life Event

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.

Contact information *(You must complete all fields)*

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

Last name	First name	Middle	Agency	Gender
				☐ M ☐ F

Contact address	☐ 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 ☐ 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 ☐ White ☐ Unknown ☐ Refuse ☐ Other
☐ Black/African American ☐ American Indian Alaska Native ☐ Native Hawaiian/Other Pacific Islander

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

Spouse/Domestic Partner Last name	First name	M.I	Birth date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision	Cancel Med Den Vision
				☐ Spouse ☐ Partner	☐ ☐	☐ ☐ ☐	☐ ☐ ☐

Address (Complete only if new):

Is this dependent Medicare eligible? ☐ No ☐ Yes

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

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

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 by an Oregon county clerk to you and your same sex partner.

☐ **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 this form. Note: Payroll/Benefit offices will not process the enrollment for the individual until all the documentation has been submitted.

Eligible dependent children *(List the eligible children you want to provide PEBB coverage. Attach a separate sheet if necessary. Required affidavits and appropriate legal documents for child by affidavit or grandchild need to be submitted along with this enrollment form. Note: Payroll/Benefit offices will not process the enrollment for the individual until all the documentation has been submitted.)*

Child — Last name	First name	M.I.	Birth date mm/dd/yyyy	Gender M F	Enroll Med Den Vision	Cancel Med Den Vision
				☐ ☐	☐ ☐ ☐	☐ ☐ ☐

Dependent Status
☐ Child ☐ Partner's child ☐ Grandchild by affidavit(both parent & 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 new):

Is this dependent Medicare eligible? ☐ No ☐ Yes

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

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

Child — Last name	First name	Middle	Birth date mm/dd/yyyy	Gender M F	Enroll Med Den Vision	Cancel Med Den Vision
				☐ ☐	☐ ☐ ☐	☐ ☐ ☐

Dependent Status ☐ Child ☐ Partner's child ☐ Grandchild by affidavit(both parent & 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? ☐ No ☐ Yes This will not affect enrollment.

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

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

Child — Last name	First name	M.I.	Birth date mm/dd/yyyy	Gender M	Gender F	Enroll Med	Enroll Den	Enroll Vision	Cancel Med	Cancel Den	Cancel Vision
				☐	☐	☐	☐	☐	☐	☐	☐

Dependent Status ☐ Child ☐ Partner's child ☐ Grandchild by affidavit(both parent & 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? ☐ No ☐ Yes

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

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

Child — Last name	First name	M.I.	Birth date mm/dd/yyyy	Gender M	Gender F	Enroll Med	Enroll Den	Enroll Vision	Cancel Med	Cancel Den	Cancel Vision
				☐	☐	☐	☐	☐	☐	☐	☐

Dependent Status ☐ Child ☐ Partner's child ☐ Grandchild by affidavit(both parent & 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? ☐ No ☐ Yes

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

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

Child — Last name	First name	M.I.	Birth date mm/dd/yyyy	Gender M	Gender F	Enroll Med	Enroll Den	Enroll Vision	Cancel Med	Cancel Den	Cancel Vision
				☐	☐	☐	☐	☐	☐	☐	☐

Dependent Status ☐ Child ☐ Partner's child ☐ Grandchild by affidavit(both parent & 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? ☐ No ☐ Yes

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

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

What changed in your life? *(The event date must be included.)* *See QSC Matrix at http://www.oregon.gov/OHA/PEBB in the summary Plan Description*	
☐ Meet eligibility for domestic partnership	Date:
☐ Birth	Date:
☐ Adoption or placement for adoption (legal documentation required)	Date:
☐ Marriage	Date:
☐ Dependent gains other medical group coverage	Date:
☐ National Medical Support Notice (NMSN)	Date:
☐ Employment status change (describe)	Date:
☐ Divorce or annulment	Date:
☐ Termination of domestic partnership	Date:
☐ Death of dependent or spouse	Date:
☐ Dependent loses other medical group coverage	Date:
☐ Employee gains other group coverage	Date:
☐ Move out of current plan's services area	Date:
☐ Loss of other group medical coverage	Date:
Tobacco midyear change info (Self): ☐ Quit ☐ Never used ☐ Medical provider advised not to quit (medical condtion) ☐ 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 condtion) ☐ Used tobacco in previous 12 months ☐ Have not used tobacco products in the previous 12 months	Date:

Did you terminate coverage for an individual?

(Name and address for all dependents is required for COBRA notice.)

Name	Address	City and State	ZIP

☐ 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 current taxable year. 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)	☐	☐	Kaiser Permanente	☐	☐
Kaiser HMO (Kaiser vision included with full time plan)	☐	☐	Delta Dental (MODA) Premier	☐	☐
Moda Summit	☐	☐	Delta Dental (MODA) PPO	☐	N/A
Moda Synergy	☐	☐	Willamette Dental	☐	N/A
PEBB Statewide PPO	☐	☐	☐ I Decline all Dental Plan Enrollment		
Providence Choice	☐	☐			

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 a new enrollment for over the guarantee issue.)

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

☐ Enroll or increase coverage

Newly eligible ONLY (Guarantee issue)

☐ $20,000 ☐ $40,000 ☐ $60,000

☐ $80,000 ☐ $100,000 +

☐ Cancel coverage

Additional amount requested
(Medical history required)

$ _____ =

☐ Reduce coverage to:

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 required for requests over the guarantee issue.)

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

☐ Enroll or increase coverage

Newly eligible ONLY (Guarantee issue)

☐ $20,000 +

☐ Cancel coverage

Additional amount requested
(Medical history required)

$ _____ =

☐ Reduce coverage to:

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.)

Dependent life insurance *(provides $5,000 of coverage for each of your PEBB eligible dependent (including spouse or domestic partner).*

☐ Enroll coverage ☐ Cancel coverage

Accidental death dismemberment (AD&D) *(available in $50,000 increments up to $500,000 for employee only or employee & dependents)*

☐ Enroll for 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.)*

Short term disability

☐ Enroll for coverage ☐ Cancel my coverage

Long term disability

☐ Enroll for coverage

- ☐ 90 days – 60%
- ☐ 90 days – 66 2/3%
- ☐ 180 days – 60%
- ☐ 180 days 66 2/3%

☐ Change my coverage (select one)

- ☐ 90 days – 60%
- ☐ 90 days – 66 2/3%
- ☐ 180 days – 60%
- ☐ 180 days 66 2/3%

Tobacco use *(If you enroll in a Medical plan and do not complete this Section a tobacco surcharge of $25.00 for employee and $25.00 for spouse/partner enrolled in medical will be deducted each month)*

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)
- ☐ I or my spouse or domestic partner quit using tobacco.
- ☐ I or my spouse or domestic partner never used tobacco

Other spousal/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)*

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 for it, $50 will be added to your monthly PEBB premium.

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

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

Name	Relationship	Address	Entity	Primary	Contingent	Whole %
			☐ Individual ☐ Trust ☐ Will	☐	☐	
			☐ Individual ☐ Trust ☐ Will	☐	☐	
			☐ Individual ☐ Trust ☐ Will	☐	☐	
			☐ Individual ☐ Trust ☐ Will	☐	☐	

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

☐ 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, and I understand that they are subject to penalty for false claims.

Employee signature _____ Date _____

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.