pebb
Public Employees' Benefit Board

Appeal Form

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

PEBB does not process insurance plan appeals. If you disagree with a plan decision, you must appeal directly to the insurance plan. See your plan's member handbook under **Benefits** at www.oregon.gov/OHA/PEBB/Pages/index.aspx.

PEBB considers appeals on eligibility decisions, enrollment errors, omissions or missed enrollment time lines. See the Summary Plan Description under **Resources** at www.oregon.gov/OHA/PEBB/Pages/spd.aspx.

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)

Your appeal *(Attach separate sheet if necessary. Attach any supporting documentation for your appeal. If this appeal is regarding your HEM health assessment completion; attach your medical plan's certificate of your completion. This appeal will not be processed without the HEM certificate.)*

a. Describe the problem.

b. Describe what you want PEBB to do.

Employee signature and authorization

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 _____

Complete and submit this form with the correct enrollment or update form and all supporting documentation to:

Public Employees' Benefit Board
500 Summer St NE, E89
Salem, OR 97301
Email: benefit.appeals@state.or.us
Fax: 503-378-5832

Keep a copy of your benefit forms for your records.

Any alteration of this form may result in it being ineffective.