



# 2012 Enrollment Self-Pay Participant

|                            |            |
|----------------------------|------------|
| <b>- Office Use Only -</b> |            |
| Approved by _____          | Date _____ |
| Effective Date _____       |            |

See the summary Plan Description to make sure you understand your choices: [www.oregon.gov/DAS/PEBB/SPD.shtml](http://www.oregon.gov/DAS/PEBB/SPD.shtml)

**1. I am enrolling as**  New Participant. Eligibility Date: \_\_\_\_\_

**2. I am**

|   |  |   |
|---|--|---|
| <input type="checkbox"/> OLCC Agent   | <input type="checkbox"/> Post Doc/J1 Visa                  | <input type="checkbox"/> Blind Business Enterprise Employee |
| <input type="checkbox"/> Foster Parent (attach copy of Foster Parent Certificate) | <input type="checkbox"/> Nurse working less than half time |   |

**3. Contact Information**  
You must complete all fields.

PEBB Benefit Number (P#####), \_\_\_\_\_

|           |            |    |          |  |
|-----------|------------|----|----------|--|
| Last Name | First Name | MI | Agency # | Sex<br><input type="checkbox"/> F <input type="checkbox"/> M |
|-----------|------------|----|----------|--|

BHS and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

|                 |   |       |      |       |     |        |
|-----------------|---|-------|------|-------|-----|--------|
| Contact Address | <input type="checkbox"/> Check if New Address | Apt # | City | State | Zip | County |
|-----------------|---|-------|------|-------|-----|--------|

|                    |               |             |                            |
|--------------------|---------------|-------------|----------------------------|
| Residence Zip Code | Work Zip Code | Work E-mail | Personal E-mail (optional) |
|--------------------|---------------|-------------|----------------------------|

|                            |            |                          |
|----------------------------|------------|--------------------------|
| Date of Birth (mm/dd/yyyy) | Work Phone | Home Phone....(optional) |
|----------------------------|------------|--------------------------|

**Under federal requirements, PEBB asks you to check Medicare Eligibility, Ethnicity and Race for you and your dependents**

|   |  |
|---|--|
| <b>Are you Medicare Eligible?</b><br><input type="checkbox"/> No <input type="checkbox"/> Yes | <b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Refuse<br><input type="checkbox"/> Non-Hispanic Non-Latino <input type="checkbox"/> Unknown |
|---|--|

**Race:** You can select more than one option. Please indicate primary

| Race Selection   | Primary                  | Race Selection  | Primary                  | Race Selection                   |
|--|--------------------------|---|--------------------------|----------------------------------|
| <input type="checkbox"/> Asian                         | <input type="checkbox"/> | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> | <input type="checkbox"/> Refuse  |
| <input type="checkbox"/> Black/African American        | <input type="checkbox"/> | <input type="checkbox"/> White                                  | <input type="checkbox"/> | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> | <input type="checkbox"/> Other                                  | <input type="checkbox"/> |                                  |

**4. Dependent Information**

Attach separate sheet if necessary. If your dependent has a different contact address, fill out 4.a on page3.

**You may not enroll children who will turn 27 in 2012.**  
**Relationship Key:** SP=Spouse, DP=Domestic Partner, CH=Employee and/or Spouse's child, DP CH=Domestic Partner's Child, AFF CH=Child by Affidavit, AFF GCH=Grandchild by Affidavit (must attach the correct Affidavit\*)

| 1 | Same address?<br>(if N, see 4.a)                      | Last Name | First Name | M | Birth Date<br>mm/dd/yyyy | Relationship | Sex<br>M F  | Enroll<br>Med Den                                 |
|---|---|-----------|------------|---|--------------------------|--------------|---|---|
|   | Y <input type="checkbox"/> N <input type="checkbox"/> |           |            |   |                          |              | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

|   |  |
|---|--|
| <b>Is this Dependent Medicare Eligible?</b><br><input type="checkbox"/> No <input type="checkbox"/> Yes | <b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Refuse<br><input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown |
|---|--|

**Race:** You can select more than one option. Please indicate primary.

| Race Selection   | Primary                  | Race Selection  | Primary                  | Race Selection                   |
|--|--------------------------|---|--------------------------|----------------------------------|
| <input type="checkbox"/> Asian                         | <input type="checkbox"/> | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> | <input type="checkbox"/> Refuse  |
| <input type="checkbox"/> Black/African American        | <input type="checkbox"/> | <input type="checkbox"/> White                                  | <input type="checkbox"/> | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> | <input type="checkbox"/> Other                                  | <input type="checkbox"/> |                                  |

|   |   |           |            |   |                          |              |   |   |
|---|---|-----------|------------|---|--------------------------|--------------|---|---|
| 2 | Same address?<br>(if N, see 4.a)                      | Last Name | First Name | M | Birth Date<br>Mm/dd/yyyy | Relationship | Sex<br>M F  | Enroll<br>Med Den                                 |
|   | Y <input type="checkbox"/> N <input type="checkbox"/> |           |            |   |                          |              | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

**Is this Dependent Medicare Eligible?**  
 No  Yes

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

**Race:** You can select more than one option. Please indicate primary.

| Race Selection   | Primary                  | Race Selection  | Primary                  | Race Selection                   |
|--|--------------------------|---|--------------------------|----------------------------------|
| <input type="checkbox"/> Asian                         | <input type="checkbox"/> | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> | <input type="checkbox"/> Refuse  |
| <input type="checkbox"/> Black/African American        | <input type="checkbox"/> | <input type="checkbox"/> White                                  | <input type="checkbox"/> | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> | <input type="checkbox"/> Other                                  | <input type="checkbox"/> |                                  |

|   |   |           |            |   |                          |              |   |   |
|---|---|-----------|------------|---|--------------------------|--------------|---|---|
| 3 | Same address?<br>(if N, see 4.a)                      | Last Name | First Name | M | Birth Date<br>Mm/dd/yyyy | Relationship | Sex<br>M F  | Enroll<br>Med Den                                 |
|   | Y <input type="checkbox"/> N <input type="checkbox"/> |           |            |   |                          |              | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

**Is this Dependent Medicare Eligible?**  
 No  Yes

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

**Race:** You can select more than one option. Please indicate primary.

| Race Selection   | Primary                  | Race Selection  | Primary                  | Race Selection                   |
|--|--------------------------|---|--------------------------|----------------------------------|
| <input type="checkbox"/> Asian                         | <input type="checkbox"/> | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> | <input type="checkbox"/> Refuse  |
| <input type="checkbox"/> Black/African American        | <input type="checkbox"/> | <input type="checkbox"/> White                                  | <input type="checkbox"/> | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> | <input type="checkbox"/> Other                                  | <input type="checkbox"/> |                                  |

|   |   |           |            |   |                          |              |   |   |
|---|---|-----------|------------|---|--------------------------|--------------|---|---|
| 4 | Same address?<br>(if N, see 4.a)                      | Last Name | First Name | M | Birth Date<br>Mm/dd/yyyy | Relationship | Sex<br>M F  | Enroll<br>Med Den                                 |
|   | Y <input type="checkbox"/> N <input type="checkbox"/> |           |            |   |                          |              | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

**Is this Dependent Medicare Eligible?**  
 No  Yes

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

**Race:** You can select more than one option. Please indicate primary.

| Race Selection   | Primary                  | Race Selection  | Primary                  | Race Selection                   |
|--|--------------------------|---|--------------------------|----------------------------------|
| <input type="checkbox"/> Asian                         | <input type="checkbox"/> | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> | <input type="checkbox"/> Refuse  |
| <input type="checkbox"/> Black/African American        | <input type="checkbox"/> | <input type="checkbox"/> White                                  | <input type="checkbox"/> | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> | <input type="checkbox"/> Other                                  | <input type="checkbox"/> |                                  |

You must submit a midyear change form to BHS within 30 days of the date when an individual you provide coverage to is no longer PEBB eligible. Individuals will be removed prospectively from coverage the last day of the month in which BHS receives the midyear change form from the employee. The exception to prospective removal from coverage is when an ex spouse, ex domestic partner or any child becomes ineligible for coverage because of divorce or dissolution of partnership. In this exception, the ineligible individuals will be removed from coverage the last day of the month in which the divorce or dissolution occurred. Late submission may affect your income taxes. In the case of retroactive terminations, you may be responsible for claims paid for the individual during the period of ineligibility. If you do not report changes of eligibility that occur before open enrollment, you may face civil or criminal charges for fraud, and PEBB may rescind coverage.

#### 4.a If you checked N above, provide contact information for dependents

| # from sec.4 | Dependent's Residence Address | City | State | Zip/Country Code |
|--------------|-------------------------------|------|-------|------------------|
|              |                               |      |       |                  |
|              |                               |      |       |                  |
|              |                               |      |       |                  |
|              |                               |      |       |                  |

#### If you listed a Domestic partner, indicate the type of Domestic Partnership

- By PEBB Affidavit\*  By Registered Certificate of Domestic Partnership for same sex individuals. (Copy not required)

**\* Affidavit Information** Affidavit is for an eligible employee and an individual of the opposite sex, or of the same sex without a Certificate of Registered Domestic Partnership. If you are adding domestic partner or a child by affidavit, you must submit the enrollment form, affidavit, and any required documentation to BHS within the allowed time, or your enrollment will not occur.

### 5. PEBB Health Care and Cost Containment Programs

Benefits offered by the Public Employees' Benefit Board include programs to improve member health and contain costs. You must select your status in the following programs:

- 5.a Health Engagement Model (HEM) Program.** Members who participate in this program will pay less for their health care benefit. Spouse or domestic partner participation is attached to the employee's status (see the HEM Agreement on page 6).
- 5.b Tobacco Use Program.** Members and spouses or domestic partners who don't currently use tobacco will pay less for their health care benefit.
- 5.c Other Employer Group Coverage Program.** Members will pay less for their health care benefit if their spouse or domestic partner enrolls in other employer group coverage if it's offered by the spouses' or domestic partners' non Oregon state agency employer.

#### 5.a Select your Status in the HEM Program

When you elect to participate in the HEM Program, you agree to statements in the HEM Agreement (see the HEM agreement on page 6).

When you elect not to participate in the HEM Program, the following amounts will be added to your monthly premium for the 2012 plan year: HEM applies to the subscriber and their spouse or domestic partner.

- Employee Only: \$20
- Employee and Spouse or Domestic Partner: \$35

- I choose **to participate** in the program, which includes my spouse/domestic partner.
- I choose **not to participate** in the program, which includes my spouse/domestic partner.
- I choose **to participate** in the program and do not have a spouse/domestic partner covered in PEBB.
- I choose **not to participate** in the program and do not have a spouse/domestic partner covered in PEBB.
- I opt out of PEBB medical plans.

### 5.b Select your Status in the Tobacco Use Program

When you or your spouse/domestic partner currently use tobacco, the following amounts will be added to your monthly premium for the 2012 plan year:

- Employee Only: \$25
- Spouse or Domestic Partner Only: \$25
- Employee and Spouse or Domestic Partner: \$50

- I currently use tobacco and, my spouse/domestic partner currently does not use tobacco.
- I currently do not use tobacco, and my spouse/domestic partner currently uses tobacco.
- My spouse/domestic partner and I currently use tobacco.
- My spouse/domestic partner and I currently do not use tobacco.
- I currently use tobacco and do not have a spouse/domestic partner enrolled covered in PEBB.
- I currently do not use tobacco and do not have a spouse/domestic partner covered in PEBB.
- I opt out of PEBB medical plans.
- My provider determined that a medical condition makes it unreasonably difficult for me to try to quit using tobacco.
- My provider advised me not to attempt to quit using tobacco.

### 5.c Select your Status in the Other-employer Group Coverage Program

When your spouse or domestic partner waives enrollment in other-medical employer group coverage available to them from a non-Oregon-state-agency the following amount will be added to your monthly premium for the 2012 plan year: \$50

- My spouse/domestic partner has PEBB coverage as an eligible employee.
- My spouse/domestic partner has other-employer group coverage available and enrolls for that coverage.
- My spouse/domestic partner has other-employer group coverage available and waives that coverage.
- My spouse/domestic partner does not have other-employer group coverage available.
- I am not enrolling a spouse or domestic partner in a PEBB medical plan.
- I opt out of PEBB medical plans.

## 6. Medical and Dental Plans

Choose your benefit election and plan. Blind Business Enterprise agents may enroll in a medical plan, only. All other self-pay participants may enroll in medical and dental plans. You must enroll in a medical plan to enroll in a dental plan.

| Medical Plan (select one) | Full-Time                | Part-time |
|---------------------------|--------------------------|-----------|
| PEBB Statewide Plan       | <input type="checkbox"/> | NA        |
| Kaiser Permanente HMO     | <input type="checkbox"/> | NA        |
| Kaiser Deductible         | <input type="checkbox"/> | NA        |
| Providence Choice         | <input type="checkbox"/> | NA        |

| Dental Plan (select one) | Full Time                | Part Time |
|--------------------------|--------------------------|-----------|
| Kaiser Permanente        | <input type="checkbox"/> | NA        |
| ODS Traditional          | <input type="checkbox"/> | NA        |
| ODS Preferred            | <input type="checkbox"/> | NA        |
| Willamette Dental        | <input type="checkbox"/> | NA        |

## 7. Participant Signature and Authorization

See Health Engagement Model (HEM) Program Agreement below. If you elect to participate in the HEM program, your signature indicates you agree.

I declare that the individuals listed on the enrollment 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 who 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.

I also understand that if I fail to report on this enrollment form 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.

This form supersedes all forms and submissions I previously made for PEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

**Send to:**

**BenefitHelp Solutions**

PO Box 67240

Portland, OR 97268-1240

Portland 503-412-4241

Toll-free 855-289-6314

Toll-free Fax 888 393-2943

**Keep a copy of all benefit documents for your records.**

# Health Engagement Model (HEM) Program Agreement

1. I will complete the Health Assessment for my health plan, either Kaiser or Providence, within 45 days of my coverage effective date. I will complete two e-lessons within 195 days of my coverage effective date.
2. I understand that answers from my Health Assessment may be shared with my primary care provider with my approval.
3. I understand that my Health Assessment will include recommendations customized for me that may include the following required standards:
  - If my waist circumference exceeds a certain number of inches, I will participate in Weight Watchers or nutritional counseling or a program of physical activity or an assessment and action plan appropriate for me developed by my provider. The number for women is 35 inches– excluding pregnant women and women within 24 months after giving birth. The number for men is 40 inches.
  - If I am a tobacco user, I will participate in a tobacco cessation program, e.g. Quit for Life, or other therapy recommended by my provider.
  - If my Health Assessment identifies stress, alcohol use or substance abuse as risks to my health, I will contact the employee assistance program or complete an e-lesson on reducing the risk, or work with my provider to develop a plan of action.
  - If a licensed medical professional from Kaiser or Providence calls me about a diagnosed chronic condition or other illness based on information submitted by my provider, I will accept or return the call to learn about potential support services for managing my condition.
4. I will review Decision Points information as available on my health plan's website prior to non-emergency surgeries or medical tests <https://members.kaiserpermanente.org/kpweb/healthency.do?hwid=share> (Kaiser) and <http://www.providence.org/healthlibrary/contentViewer.aspx?hwid=share> (Providence).
5. I will document the actions I take (and, if applicable, those taken by my spouse or domestic partner) on the HEM log or in a similar form. My documentation will include dates of completing the Health Assessment and e-lessons, contacts with a case or disease manager, and participation in program requirements.
6. If I am enrolling my spouse or domestic partner for coverage, I have informed my spouse or domestic partner that he or she must individually complete our health plan's Health Assessment and two e-lessons within the given time frames and comply with the recommendations of the HEM Agreement in 3-5, above.
7. If a medical condition or disability makes it unreasonably difficult for me (or my spouse or domestic partner) to achieve a standard described in 3 (above), or if attempting to do so is medically inadvisable, a reasonable alternative to the standard will be provided.
8. I understand that I will pay a monthly HEM surcharge if either I or my spouse or domestic partner misses deadlines for completing the Health Assessment and two e-lessons.