PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Enrollment Form

Eligible Retiree & Dependents

- Office Use Only -	
Approved by __	Date___
Effective Date_______	

Your choices on coverage as a PEBB retiree are determined by PEBB administrative rules. Read the Summary Plan Description to make sure you understand your choices: www.oregon.gov/DAS/PEBB/SPD.shtml

Submit completed form to BenefitHelp Solutions (BHS), the administrator.

1. I am eligible to enroll because

☐ **I'm a new retiree. Retirement Date: _________**	☐ **Annual Plan Change Period**

2. I am enrolling as a

☐ **PEBB Retiree**	☐ **PEBB Member through eligibility of a PEBB Retiree**	
	PEBB retiree name:	Date of Birth:

3. Contact Information

PEBB Benefit Number (P#########)

Last Name	First Name	MI	Gender ☐ F ☐ M

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

Contact Address ☐ Check if New Address	Apt #	City	State	Zip	County

Residence Zip Code	Personal E-mail
Date of Birth _ _ / _ _ / _ _ _ _	Home Phone ( ) -

4. Dependent Information

Attach separate sheet if necessary

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* (must attach Affidavit* of Dependency)

Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Relationship	Gender M	Gender F	Enroll Med	Enroll Den
					☐	☐	☐	☐
					☐	☐	☐	☐

Dependent Certification ages 19 up to 24

I certify that dependents age 19 up to 24 listed here are eligible for coverage under PEBB rules.

Certification applies to: ☐ Current Plan Year (new retiree) ☐ Coming Plan Year (plan change period)

Type of Domestic Partnership

☐ By PEBB Affidavit* ☐ By Registered Certificate

***Affidavit Information**

If you are adding a dependent or domestic partner by affidavit, you must submit the affidavit to the administrator within five business days of this enrollment, or the individual's coverage will be terminated back to the effective date.

5. Medical and Dental Plans

Choose your benefit election and plan. You may enroll in a Full-time Plan or a Part-time & Retiree Plan.

I elect to (select one):

- ☐ Enroll in PEBB Medical coverage only
- ☐ Enroll in PEBB Dental coverage only
- ☐ Enroll in both PEBB Medical and Dental coverage

Medical Plan* (select one)	**Full-time Plan**	**Part-time & Retiree Plan**	**Dental Plan*** (select one)	**Full-time Plan**	**Part-time & Retiree Plan**
PEBB Statewide Plan	☐	☐	Kaiser Permanente	☐	☐
Kaiser Permanente	☐	☐	ODS Traditional	☐	☐
Providence Choice	☐	☐	ODS Preferred	☐	
			Willamette Dental	☐	

***You cannot add medical or dental coverage during the annual plan change period.**

6. Medicare Coverage

If you or anyone you cover is eligible for Medicare, provide the following information. See the Medicare card for effective dates.

Name	Part A Effective Date	Part B Effective Date
	__/__/____	__/__/____
	__/__/____	__/__/____

7. Employee Signature and Authorization

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. I agree to self-pay premiums. I agree to submit monthly payments by the date specified, or my coverage will terminate.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

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 perjury.

_______________________________ _______________

Retiree/Subscriber Signature Date

Send to:

Benefit Help Solutions
PO Box 67240
Portland, OR 97268-1240

Portland (503) 765-3581
Toll-free (800) 556-3137
Toll-free Fax (888) 393-2943

Keep a copy of all benefit documents for your records.