



# Enrollment Form

## Self-Pay Participant

- Office Use Only -
Approved by _____ Date _____
Effective Date _____

See the Summary Plan Description for more information: [www.oregon.gov/DAS/PEBB/SPD.shtml](http://www.oregon.gov/DAS/PEBB/SPD.shtml)

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

### 1. I am Enrolling as a

<input type="checkbox"/> New Participant. Eligibility Date: _____	<input type="checkbox"/> PEBB Member during Open Enrollment
---	---

### 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

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

Last Name	First Name	MI	Agency #	Gender <input type="checkbox"/> F <input type="checkbox"/> M		
BHS and the plans in which you enroll will send <b>all</b> 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 _ _ / _ _ / _ _ _ _		Work Phone ( ) -		Home Phone	(optional) ( ) -	

### 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		Enroll	
					M	F	Med	Den
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### 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 participant)  Coming Plan Year (Open Enrollment)

#### 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

Blind Business Enterprise Employees may enroll only in Medical coverage.

I elect to (select one):

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

Medical Plan (select one)	Full-time Plan	Part-time Plan	Dental Plan (select one)	Full-time Plan	Part-time Plan
PEBB Statewide Plan	<input type="checkbox"/>	<input type="checkbox"/>	Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>	ODS Traditional	<input type="checkbox"/>	<input type="checkbox"/>
Providence Choice	<input type="checkbox"/>	<input type="checkbox"/>	ODS Preferred Option	<input type="checkbox"/>	
			Willamette Dental	<input type="checkbox"/>	

## 6. Medicare Coverage Information

I am covered by Medicare     A dependent is covered by Medicare     Not Applicable

## 7. Participant 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.

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

\_\_\_\_\_  
Date

<b>Send to:</b>	<b>Benefit Help Solutions</b>	Portland (503) 765-3581
	PO Box 67240	Toll-free (800) 556-3137
	Portland, OR 97268-1240	Toll-free Fax (888) 393-2943

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