



2012 Enrollment

Active Employees

- Office Use Only -

Approved by _____ Date _____

Effective Date _____

See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml

1. I am Enrolling as

<input type="checkbox"/> Newly Eligible Employee	Coverage begins the first of the month after you become eligible and your agency receives this form and all required documentation.
<input type="checkbox"/> Correction to New Hire Enrollments	I am submitting this form to correct an error I made in my enrollments as a newly eligible employee. (Complete Section 2 and only the sections in which you are requesting a correction).

2. Contact Information

You must complete all fields.

PEBB Benefit Number (P#####), OR Number, University ID

Last Name	First Name	MI	Agency #	Sex <input type="checkbox"/> F <input type="checkbox"/> M
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PEBB 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
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Residence Zip Code	Work Zip Code	Work E-mail	Personal E-mail (optional)
Date of Birth (mm/dd/yyyy)		Home Phone (optional)	Work Phone

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

Are you Medicare Eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes	Ethnicity:	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Refuse
		<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"/>	

3. Dependent Information

List all dependents you want covered for 2012. Attach separate sheet if necessary. If your dependent has a different contact address, fill out section 3.a.

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*)

#	Same address? (if N, see 3.a)	Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Sec M F	Enroll Med Den
1	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? <input type="checkbox"/> No <input type="checkbox"/> Yes	Ethnicity:	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Refuse
		<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"/>	

	Same address? (if N, see 3.a)	Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Sex M F	Enroll Med Den
2	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"/>	

	Same address? (if N, see 3.a)	Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Sex M F	Enroll Med Den
3	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"/>	

	Same address? (if N, see 3.a)	Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Sex M F	Enroll Med Den
4	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"/>	

- 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.

4.b Select your Status in the Tobacco Use Program

When you or your spouse/domestic partner currently use tobacco, the following amounts will be deducted from your pay every month 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 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.

4.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 deducted from your pay every month 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.

5. Medical and Dental Plans

Choose your plan elections. Part-time employees are eligible for both part time and full time plans.

Medical Plan (select one)			Alternate Election: <input type="checkbox"/> Decline all PEBB Benefits		
	Full Time	Part-time	Dental Plan (select one)	Full Time	Part-time
PEBB Statewide Plan	<input type="checkbox"/>	<input type="checkbox"/>	Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser Permanente HMO	<input type="checkbox"/>	<input type="checkbox"/>	ODS Traditional	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser Deductible	<input type="checkbox"/>	<input type="checkbox"/>	ODS Preferred	<input type="checkbox"/>	NA
Providence Choice	<input type="checkbox"/>	<input type="checkbox"/>	Willamette Dental	<input type="checkbox"/>	NA
Medical Opt Out (complete section 6)	<input type="checkbox"/> Medical Opt Out Only* <input type="checkbox"/> Medical & Dental Opt Out*				

*Opt out is a choice of Medical plan. You may opt out of Medical if you have other employer-sponsored group Medical coverage. You may opt out of combined Medical and Dental if you have other employer-sponsored group coverage for both Medical and Dental. You may not opt out of Dental alone.

6. Other Group Coverage

To Opt Out you must complete this section and provide proof of other employer-sponsored group coverage to your agency along with this enrollment form within the allowed time. If you don't, you will be enrolled on the employee-only tier of the PEBB Statewide Plan and the ODS Traditional dental plan.

Plan Type:	Plan	Carrier	Policy Number	Group Number
	<input type="checkbox"/> Medical			
	<input type="checkbox"/> Dental			
Subscriber in Other Group Plan		Employer	Effective Date (mm/dd/yyyy)	

Complete sections 7-10 only to enroll or to change current elections.

7. Optional Life Insurance (Any coverage above your guarantee issue requires a medical history statement)

Dependent Life Insurance \$5,000 of coverage for each eligible dependent (including spouse or domestic partner). Medical history is not required		
<input type="checkbox"/> Enroll for Coverage		<input type="checkbox"/> Cancel Coverage
Employee Optional Life Insurance (\$20,000 increments, maximum \$600,000)		<input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Reduce Coverage to: _____
Newly Eligible ONLY (Guarantee Issue)	Amount Requested (Additional- Medical History Required)	Total Amount
\$ _____ (\$20,000 or \$40,000) +	\$ _____ =	\$ _____

Spouse or Domestic Partner Optional Life Insurance (\$20,000 increments, maximum \$400,000)		
<input type="checkbox"/> Enroll for Coverage		<input type="checkbox"/> Cancel Coverage
<input type="checkbox"/> Change Coverage		<input type="checkbox"/> Reduce Coverage to: _____
<input type="checkbox"/> Cancel Coverage		
Newly Eligible ONLY (Guarantee Issue)	Amount Requested (Additional- Medical History Required)	Total Amount
\$ _____ (\$20,000) +	\$ _____ =	\$ _____

8. Disability Insurance (replaces a portion of salary when employee is eligible for the benefit)

Short Term Disability	<input type="checkbox"/> Enroll for Coverage	<input type="checkbox"/> Cancel Coverage	
Long Term Disability	<input type="checkbox"/> Enroll for Coverage	Waiting Periods – Coverage Level (select one)	
	<input type="checkbox"/> Change Coverage	<input type="checkbox"/> 90 days – 60%	<input type="checkbox"/> 180 days – 60%
	<input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> 90 days – 66 2/3%	<input type="checkbox"/> 180 days – 66 2/3%

9. Accidental Death & Dismemberment (AD&D)

<input type="checkbox"/> Enroll for Employee Only Coverage	<input type="checkbox"/> Change Coverage Amount
<input type="checkbox"/> Enroll for Employee and Dependents Coverage	<input type="checkbox"/> Cancel Coverage
Total Amount	\$ _____ (\$50,000 increments, maximum \$500,000)

10. Beneficiary Designation

- The Standard Order of Survivorship (no beneficiary listed)
 Designate the following as beneficiary

Entity Codes: I = Individual, W = Will, T = Living Trust,

Total of primary percentages must = 100%

Total of contingent percentages must = 100%

Name	Address	Entity (circle one)	Primary	Contingent	Whole %
		I W T	<input type="checkbox"/>	or <input type="checkbox"/>	%
		I W T	<input type="checkbox"/>	or <input type="checkbox"/>	%
		I W T	<input type="checkbox"/>	or <input type="checkbox"/>	%
		I W T	<input type="checkbox"/>	or <input type="checkbox"/>	%

11. Employee 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.

Employee Signature

Date

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

Submit completed form to your agency payroll or university benefits office.

Keep a copy of your benefit forms 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.