Midyear Change

- Office Use Only -
Approved by ___ **Date**___
Effective Date_______

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

1. Because I experienced a qualified midyear change, I want to

☐ Add an individual to coverage ☐ Remove an individual from coverage**(complete Section 5)** ☐ Change my current plan enrollments

2. Contact Information

You must complete all fields.

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

Last Name	First Name	MI	Agency #	Sex ☐ F ☐ M

PEBB 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	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? ☐ 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
☐ Asian	☐	☐ Native Hawaiian/Other Pacific Islander	☐	☐ Refuse
☐ Black/African American	☐	☐ White	☐	☐ Unknown
☐ American Indian/Alaska Native	☐	☐ Other	☐	

3. Dependent Information

Only list dependents that are affected by the change. Attach separate sheet if necessary. If your dependent has a different contact address, fill out the next section.

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? (if N, see 3.a)	Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Sex M	Sex F	Enroll Med	Enroll Den	Terminate Coverage
	Y ☐ N ☐						☐	☐	☐	☐	☐

Is this Dependent Medicare Eligible? ☐ No ☐ Yes

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

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

Race Selection	Primary	Race Selection	Primary	Race Selection
☐ Asian	☐	☐ Native Hawaiian/Other Pacific Islander	☐	☐ Refuse
☐ Black/African American	☐	☐ White	☐	☐ Unknown
☐ American Indian/Alaska Native	☐	☐ Other	☐	

#	Same address? (if N, see 3.a)	Last Name	First Name	MI	Birth Date mm/dd/yyyy	Relationship	Sex M F	Enroll Med Den	Terminate Coverage
2	Y ☐ N ☐						☐ ☐	☐ ☐	☐

Is this Dependent Medicare Eligible? ☐ No ☐ Yes	Ethnicity:	☐ Hispanic ☐ Non-Hispanic/Non-Latino	☐ Refuse ☐ Unknown

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

Race Selection	Primary	Race Selection	Primary	Race Selection
☐ Asian	☐	☐ Native Hawaiian/Other Pacific Islander	☐	☐ Refuse
☐ Black/African American	☐	☐ White	☐	☐ Unknown
☐ American Indian/Alaska Native	☐	☐ Other	☐	

#	Same address? (if N, see 3.a)	Last Name	First Name	MI	Birth Date mm/dd/yyyy	Relationship	Sex M F	Enroll Med Den	Terminate Coverage
3	Y ☐ N ☐						☐ ☐	☐ ☐	☐

Is this Dependent Medicare Eligible? ☐ No ☐ Yes	Ethnicity:	☐ Hispanic ☐ Non-Hispanic/Non-Latino	☐ Refuse ☐ Unknown

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

Race Selection	Primary	Race Selection	Primary	Race Selection
☐ Asian	☐	☐ Native Hawaiian/Other Pacific Islander	☐	☐ Refuse
☐ Black/African American	☐	☐ White	☐	☐ Unknown
☐ American Indian/Alaska Native	☐	☐ Other	☐	

You must submit a midyear change form to your agency 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 the agency 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.

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

#	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 (Copy not required)

***Affidavit** If you are adding a child or domestic partner by affidavit, you must submit the enrollment form, affidavit, and any required documentation to your agency payroll or university benefit office along with this enrollment or your enrollment will not occur.

4. What Changed in Your Life? (The event date must be included)

See QSC Matrix at http://www.oregon.gov/DAS/PEBB/docs/SPD/QSCmatrix.pdf for more information.

☐ Marriage	Date: _ _ / _ _ / _ _ _	☐ Divorce or annulment	Date: _ _ / _ _ / _ _ _
☐ Met eligibility for Domestic Partnership	Date: _ _ / _ _ / _ _ _	☐ Termination of Domestic Partnership	Date: _ _ / _ _ / _ _ _
☐ Birth	Date: _ _ / _ _ / _ _ _	☐ Death of a dependent or spouse	Date: _ _ / _ _ / _ _ _
☐ Adoption or placement for adoption (legal documentation required)	Date: _ _ / _ _ / _ _ _	☐ Dependent ceases to meet eligibility	Date: _ _ / _ _ / _ _ _
☐ Dependent meets eligibility	Date: _ _ / _ _ / _ _ _	☐ Involuntary loss of other group coverage	Date: _ _ / _ _ / _ _ _
☐ Dependent gains other group coverage **Must complete Section 7**	Date: _ _ / _ _ / _ _ _	☐ Employee gains other group medical coverage **Must complete Section 7**	Date: _ _ / _ _ / _ _ _
☐ National Medical Support Notice (NMSN)	Date: _ _ / _ _ / _ _ _	☐ Move out of current plan's service area	Date: _ _ / _ _ / _ _ _
☐ Employment status change (describe)	Date: _ _ / _ _ / _ _ _ ________________	☐ Other reason (describe): ________________ ________________	Date: _ _ / _ _ / _ _ _
☐ Loss of other group medical coverage.	Date: _ _ / _ _ / _ _ _		

5. Did you terminate coverage for a spouse, domestic partner or dependent?

Name and address for all dependents is required for COBRA notice.

Name	Address City State Zip

6. Midyear Enrollment Update

You may only make changes to your benefit plan enrollments (section 6) that are consistent with your midyear event. Some events may not allow your requested change. See "How to Enroll" in the Summary Plan Description: www.oregon.gov/DAS/PEBB/docs/SPD/subsections/HowToEnroll.pdf and the QSC matrix: http://www.oregon.gov/DAS/PEBB/docs/SPD/QSCmatrix.pdf.

6a. Medical and Dental Plans

Alternate Election: ☐ Decline PEBB Benefits

Choose your plan elections. Part-time employees can choose any plan, including "Part-time."

Medical Plan (select one)		"Part-time"
PEBB Statewide Plan	☐	☐
Kaiser Permanente	☐	☐
Kaiser Deductible	☐	☐
Providence Choice	☐	☐

Dental Plan (select one)		"Part-time"
Kaiser Permanente	☐	☐
ODS Traditional	☐	☐
ODS Preferred	☐	
Willamette Dental	☐	

Medical Opt Out* (Must fill out Section 8)	
☐ Medical Opt Out Only*	*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.
☐ Medical & Dental Opt Out*	

6b. Optional Life Insurance

(Any coverage above guarantee requires a medical history statement)

Employee Optional Life Insurance ($20,000 increments, maximum $600,000)		☐ Cancel Coverage ☐ Reduce Coverage to:__________________	
Current Coverage (If any)	**Newly Eligible ONLY** (Guarantee Issue)	**Amount Requested** (Additional)	**Total Amount Requested**
$__________________ +	$_________ ($20,000 or $40,000) +	$______________ =	$______________

Spouse or Domestic Partner Optional Life Insurance ($20,000 increments, maximum $400,000)		☐ Cancel Coverage ☐ Reduce Coverage to:__________________	
Current Coverage (If any)	**Newly Eligible ONLY** (Guarantee Issue)	**Amount Requested** (Additional)	**Total Amount Requested**
$__________________ +	$____________ ($20,000) +	$______________ =	$______________

Dependent Life Insurance $5,000 of coverage for each eligible dependent (including spouse or domestic partner). Medical history is **not** required.	
☐ Enroll for Coverage	☐ Cancel Coverage

6c. Accidental Death & Dismemberment (AD&D)

☐ Enroll for Employee Only Coverage ☐ Enroll for Employee and Dependents Coverage	☐ Change Coverage Amount ☐ Cancel Coverage
Total Amount	$ ________________ ($50,000 increments, maximum $500,000)

6d. Disability Insurance (replace a portion of salary when employee is eligible for the benefit)

Short Term Disability	☐ Enroll for Coverage ☐ Cancel Coverage	
Long Term Disability	☐ Enroll for Coverage ☐ Change Coverage ☐ Cancel Coverage	**Waiting Periods – Coverage Level** (select one) ☐ 90 days – 60% ☐ 180 days – 60% ☐ 90 days – 66 2/3% ☐ 180 days – 66 2/3%

6e. 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.

☐ My ☐ My spouse's or domestic partners' provider determined that a medical condition makes it unreasonably difficult to try to quit using tobacco.
☐ My ☐ My spouse's or domestic partners' provider advised not to attempt to quit using tobacco.

6f. Other-employer Group Coverage Program

Change in this program must be consistent with the qualifying event and are effective the first of the month following receipt of this form by agency/university benefit office.

When your spouse or domestic partner waives enrollment in other-medical employer group coverage available to them from a non-Oregon-state-agency $50 will be deducted from your monthly pay.

- ☐ 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 overage 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.

6g. HEM Program

Changes in this program must be consistent with the qualifying event and are effective the first of the month following receipt of this form by agency/university benefit office.

When you elect to participate in the HEM Program, you agree to statements in the HEM Agreement .

When you elect not to participate in the HEM Program, the following amounts will be deducted from your monthly pay.

- 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.

7. 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
	☐ Medical			
	☐ Dental			

Principal Enrollee in Other Group Plan	Employer	Effective Date
		_ _ / _ _ / _ _ _ _

8. Beneficiary Designation

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

Entity Codes: I = Individual, W = Will, T = Trust,
Total of primary percentages must = 100%
Total of contingent percentages must = 100%

Name	Address	Entity (circle one)	Primary Contingent	Whole %
		I W T	☐ or ☐	%
		I W T	☐ or ☐	%
		I W T	☐ or ☐	%
		I W T	☐ or ☐	%

9. 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. 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 __________**.

For active employees:

Send this completed form to: Agency or University Benefit office

For COBRA, Retiree or other Self-Pay Participant:

Send this completed form to: BenefitHelp Solutions (BHS)
PO Box 67240 Portland, OR 97268-1240

Keep a copy of all benefit documents for your records.
Any alterations on this form may result in it being ineffective.

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.