Active Employee Open Enrollment for 2018 Oct. 1 – Oct. 31, 2017

Open Enrollment Corrections (see dates below)

Office use only
Approved by: ____________
Approved date: ____________
Effective date: ____________

See the Summary Plan Description for more information on benefits at www.oregon.gov/OHA/PEBB. **Submit completed form to your agency payroll or university benefits office. Keep a copy of your benefit forms for your records. Any alteration of this form may result in it being ineffective.**

I am enrolling as

☐ Open Enrollment – Oct. 1 to Oct. 31, 2017
☐ Open Enrollment Correction – Can be submitted through January 31, 2018. Note – HEM is not correctable
☐ Newly hired in Oct. 2017 Open Enrollment

Contact information *(You must complete all fields)*

PEBB benefit number (P########), OR#, University ID or Lottery ID					
Last name	First name	Middle		Agency	Gender ☐ M ☐ F
Contact address	☐ Check if new address	Apartment #	City	State	ZIP
Residence ZIP code	Work ZIP code	Work email		Personal email (optional)	
Date of birth (mm/dd/yyyy)		Work phone		Home phone (optional)	

Are you Medicare eligible? ☐ No ☐ Yes This will not affect enrollment.

Are you serving or did you ever serve in the military? ☐ No ☐ Yes

Do you authorize PEBB to send your name and address to Oregon Department of Veteran's affairs (ODVA) for the purpose of receiving benefit information? ☐ No ☐ Yes

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

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

Family coverage *(List all eligible family members you want to provide coverage for in 2018. Attach additional dependent sheet if necessary.)*

Spouse/Domestic Partner Last name	First name	Middle	Birth date mm/dd/yyyy	Relationship	Gender M	Gender F	Enroll Med	Enroll Den	Enroll Vision
				☐ Spouse ☐ Partner	☐	☐	☐	☐	☐

Address: Complete only if different

Is this dependent Medicare eligible? ☐ No ☐ Yes This will not affect enrollment.

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

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

If you listed a Domestic Partner, mark the type of Domestic Partnership

(Affidavits need to be to your payroll/HR by Nov. 7, 2017 or enrollments will not take place.)

☐ **Registered Certificate of Domestic Partnership** (Copy not required) You have a registered certificate issued by an Oregon county clerk to you and your same sex partner.

☐ **PEBB Domestic Partner Affidavit** is a partnership between an eligible employee and an individual of the opposite sex, or same sex without a Certificate of Registered Domestic Partnership.

Eligible dependent children

(List the eligible children you want to provide coverage for in 2018. Attach a separate sheet if necessary. Required affidavits and appropriate legal documents for child by affidavit or grandchild need to be to your payroll/HR by Nov. 7, 2017 or enrollments will not take place.)

Child — Last name	First name	Middle	Birth date mm/dd/yyyy	Gender M	Gender F	Enroll Med	Enroll Den	Enroll Vision
				☐	☐	☐	☐	☐

Dependent Status: ☐ Child ☐ Partner's child ☐ Grandchild by affidavit ☐ Step Child ☐ Child by affidavit (includes foster child and child placed for adoption. When adoption is final provide paperwork to your payroll/HR to have status changed to child)

Address: Complete only if different

Is this dependent Medicare eligible? ☐ No ☐ Yes This will not affect enrollment.

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

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

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				☐ ☐	☐ ☐ ☐

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☐ Decline all PEBB benefits

If you decline core benefits (medical/dental/vision/employee basic life), you're choosing to not participate in any of the PEBB programs. You will not receive cash in lieu of the medical coverage and you are not eligible to enroll in any PEBB plans.

Health Engagement Model(HEM) Program

If you were a 2017 HEM participant and you are enrolling for 2018 HEM, you must answer the following question. (check one)

Did you complete two health actions as part of 2017 HEM participation? ☐ Yes ☐ No

2018 HEM Enrollment (Check one) Note: If you Opt Out of Medical you are not eligible to participate in the HEM program.

☐ I choose **to participate** in the program. I understand, that I must complete a health assessment in my current (2017) medical plan by 10/31/17

☐ I choose **not to participate** in the program.

Medical plans/Dental plans *(Some plans have specific service areas and may not be available to you, be sure to review plan availability for your area.)*

Medical Opt Out To enroll in Opt out you must attest at enrollment and each plan year thereafter to having an alternative minimum essential medical coverage. You do not need to provide proof of alternative medical coverage. See information at: http://www.oregon.gov/oha/pebb/benefits/opt-out.pdf

Opting Out of a medical enrollment is conditioned upon my understanding and attesting that the following statements are true:

- I and all other individuals for whom I reasonably expect to claim a personal tax exemption deduction for have, or will have, an alternative medical coverage considered to be minimum essential coverage through an employer sponsored medical plan for the taxable year 2018. The following coverages are not eligible to Opt Out against: Oregon Health Plan/Medicaid, Veteran's Benefit Administration Programs, Student Health, and individual market coverage.
- I understand my employer will not pay the monthly opt-out payment to me if my employer knows or has reason to know that myself or any other member of my expected tax family does not have or will not have the alternative coverage.
- I understand that I must renew this attestation each plan year and applicable tax year for which I want the Opt Out to apply.

☐ **Enroll me in Opt Out. By checking this box and signing the form I verify the above statements are true.**

Medical	Full time	Part time
Kaiser Deductible (Kaiser vision included with full time plan)	☐	☐
Kaiser HMO (Kaiser vision included with full time plan)	☐	☐
Moda Summit	☐	☐
Moda Synergy	☐	☐
PEBB Statewide PPO	☐	☐
Providence Choice	☐	☐

Dental	Full time	Part time
Kaiser Permanente	☐	☐
MODA Premier	☐	☐
MODA PPO	☐	N/A
Willamette Dental	☐	N/A
☐ I Decline all Dental Plan Enrollment		

Vision plan

☐ Enroll VSP Basic Plan ☐ Enroll VSP Plus — Includes the Basic Plan and PLUS additional benefits	☐ I Decline all VSP Enrollment

Optional life insurances *(Complete only the sections required for enrollment.)*

Employee optional life insurance

(Medical history statement is required for a new enrollment for over the guarantee issue.)
For rates information see www.oregon.gov/OHA/PEBB

($20,000 increments, with a maximum of $600,000)

☐ Enroll for coverage __________ (medical history statement required by 12/15/17)	☐ Increase coverage __________ (medical history statement required by 12/15/17)	☐ Reduce coverage __________

Required: Tobacco use status, check one

☐ I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)
☐ I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

Spouse or Domestic Partner optional life insurance

(Medical history statement required for requests over the guarantee issue.)
For rates information see www.oregon.gov/OHA/PEBB

($20,000 increments up to maximum of $400,000)

☐ Enroll for coverage __________ (medical history statement required by 12/15/17)	☐ Increase coverage __________ (medical history statement required by 12/15/17)	☐ Reduce coverage __________

Required: Tobacco use status, check one

☐ I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)
☐ I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

Dependent life insurance *provides $5,000 of coverage for each of your PEBB eligible dependent (including spouse or domestic partner). For rates information see www.oregon.gov/OHA/PEBB*

☐ Enroll coverage	☐ Cancel coverage

Accidental death dismemberment (AD&D)

For rates information see www.oregon.gov/OHA/PEBB

☐ Enroll for coverage ☐ Cancel coverage ☐ Change coverage

☐ Employee only coverage ($50,000 increments, max $500,000)	Total benefit coverage amount $ __________
☐ Employee & Dependent coverage ($50,000 increments, max $500,000)	Total benefit coverage amount $ __________

Disability insurance *(The benefits will replace a portion of salary when the employee has a qualified disability claim.) For rates information see www.oregon.gov/OHA/PEBB*

Long term disability

☐ Enroll for coverage	☐ Change my coverage (select one)	☐ Cancel my coverage
☐ 90 days waiting period – 60% (.0051)	☐ 90 days waiting period – 60% (.0051)	
☐ 90 days waiting period – 66 2/3% (.0106)	☐ 180 days waiting period – 60% (.0018)	
☐ 180 days waiting period – 60% (.0018)	☐ 90 days waiting period – 66 2/3% (.0106)	
☐ 180 days waiting period – 66 2/3% (.0027)	☐ 180 days waiting period – 66 2/3% (.0027)	

Short term disability — *For rates information see www.oregon.gov/OHA/PEBB*

☐ Enroll for coverage ☐ Cancel my coverage

Tobacco use *(If you enroll in a Medical plan and do not complete this Section a tobacco surcharge ($25.00 per employee and $25.00 for spouse/partner enrolled in medical) will be deducted each month from your 2018 pay for PEBB coverage.)*

Check one box:

- ☐ I currently use tobacco and, my spouse/domestic partner currently does not use tobacco. ($25)
- ☐ I currently do not use tobacco, and my spouse/domestic partner currently uses tobacco. ($25)
- ☐ Both my spouse/domestic partner and I currently use tobacco. ($50)
- ☐ Both my spouse/domestic partner and I currently do not use tobacco. ($0)
- ☐ I currently use tobacco and do not have a spouse/domestic partner covered in PEBB. ($25)
- ☐ I currently do not use tobacco and do not have a spouse/domestic partner covered in PEBB. ($0)
- ☐ I do not enroll in PEBB medical plans.
- ☐ My or ☐ My spouse's or domestic partners' provider advised not to quit using tobacco (Medical Waiver). ($0)

Other spousal/partner employer group coverage

(If you enroll in a medical plan and cover a spouse or partner you need to complete this section or a surcharge will be deducted each month from your 2018 pay.)

When your spouse or domestic partner is enrolled in your PEBB medical coverage and has access to medical coverage from their employer's sponsored group plan (i.e., a non- State of Oregon) but does not enroll for it, $50 will be added to your monthly PEBB premium.

Check one box:

- ☐ My spouse/domestic partner has PEBB coverage as an eligible employee (Includes a spouse who enrolls in Opt Out). ($0)
- ☐ My spouse/domestic partner has other employer group coverage available and enrolls for that coverage. ($0)
- ☐ My spouse/domestic partner has other-employer group overage available, but does not enroll in that coverage and is enrolled in PEBB coverage. ($50)
- ☐ My spouse/domestic partner does not have other-employer group coverage available. ($0)
- ☐ I do not cover a spouse or domestic partner in a PEBB medical plan. ($0)

Beneficiary designation *(Total of primary and contingent percentages must = 100%. You can change your beneficiary designation yourself anytime during the year at https://pebbbenefits.oha.oregon.gov/bms_web/!pb.main)*

☐ Standard order of survivorship (No beneficiary listed) ☐ Designate the following as beneficiary (List beneficiary)

Name	Relationship	Address	Entity	Primary	Contingent	Whole %
			☐ Individual ☐ Trust ☐ Will	☐	☐	
			☐ Individual ☐ Trust ☐ Will	☐	☐	
			☐ Individual ☐ Trust ☐ Will	☐	☐	
			☐ Individual ☐ Trust ☐ Will	☐	☐	

Note: that a change in beneficiary will revoke any previous selections.

Employee signature and authorization *(If you elected the Medical Opt Out, your signature indicates you agree to the terms of the Opt Out alternative coverage self-attestation.)*

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.

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

Employee signature _______________ Date _______________

2018 Health Engagement Model (HEM) Agreement

1. I will enroll for 2018 HEM during Open Enrollment (Oct. 1 – Oct. 31, 2017) and complete the health assessment in my current 2017 health plan between Sept. 1 to Oct. 31, 2017. I am responsible for printing a completion certificate for the health assessment from my current 2017 medical web site for verification of completion.

2. I understand that:

   a. By enrolling for HEM and completing the health assessment during Open Enrollment, I will receive a taxable health incentive in monthly pay beginning January 2018 ($17.50 employee only).

   b. If I don't enroll for HEM and complete the health assessment during Open Enrollment, I will not receive the health incentive, and my 2018 medical coverage will include a $100 added deductible per covered individual (to a family maximum of three individuals).

3. I will take and self-track two healthy activities by the time of my enrollment in a health plan during Open Enrollment for the 2019 Plan Year. PEBB does not track activities for employees.

4. I understand that I will not be eligible to participate in the 2019 HEM if I do not complete and track two Healthy activities by my enrollment during Open Enrollment for the 2019 Plan Year. PEBB does not track an employee's activities.

5. I understand that if I am unable to enroll in HEM due to a medical condition or disability, am out of the country, serving in the military overseas or incarcerated that I am responsible for requesting an exception to my current 2017 medial plan before Oct. 31, 2017.