Enrollment and Change Form
PPS Active Employees and Retirees

PPS HR Only
Effective Date:

☐ **New Hire** ☐ **New Retiree** ☐ **Change** ☐ **Open Enrollment**

SECTION A - EMPLOYEE INFORMATION

Name: (Print) ______________________ Employee ID# OR SS# __________________
Date of Birth: ______________ Marital Status: _______ Male☐ Female☐

Ethnicity (select one): ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (select one or more, circle one as primary): ☐Asian ☐Black/African American ☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Refused ☐ Unknown

Employee Address:__________________________ Email: (W)
☐Check if new address Street Email: (H)
Phone: (W)
City State Zip Phone: (H)
Mailing Address: (if different from above)
Work Location:__________________________ Job Title:__________________

Employee Classification:	☐ Non-Rep	☐ SEIU	(If Retiree, use classification when active)
Employee Status:	☐ Full Time	☐ Part Time	(If Retiree, use Status when active)

Qualified Status Change: Mark one and enter in the date of event.

☐ New Hire	Date: ____________	☐ Marriage (attach Marriage Certificate)	Date: ____________
☐ New Retiree	Date: ____________	☐ Divorce (attach Divorce Decree)	Date: ____________
☐ Dependent meets eligibility	Date: ____________	☐ Qualified Domestic Partner	Date: ____________
☐ Dependent ceases to meet eligibility	Date: ____________	☐ Death of spouse/dependent	Date: ____________
☐ Birth / Adoption	Date: ____________	☐ Employment status change	Date: ____________
☐ Gain/Loss of Other Coverage (Attach Certificate of Creditable Coverage)	Date: ____________	☐ Other ____________________	Date: ____________

SECTION B - MEDICAL, DENTAL, AND VISION PLAN ELECTIONS

Medical	☐ ODS Plan 6	☐ ODS Plan 7	☐ ODS Plan 9 *	☐ Kaiser HMO Plan 1A	☐Waive	☐ Opt Out**
Vision ***	☐ ODS	☐ Kaiser (w/ Kaiser medical only)		☐ Waive (Non-Rep ONLY)		☐ Opt Out**
Dental ***	☐ ODS	☐ Kaiser (w/ Kaiser medical only)		☐ Waive		☐ Opt Out**

*ODS Plan 9: If enrolled in Plan 9, you will be automatically be enrolled in the Health Reimbursement Arrangement (HRA)

**Opt Out: To Opt Out and receive the cash incentive, you must complete section D on back of this page

*** Vision/Dental: If you waive Dental and/or Vision coverage when initially eligible, then enroll in one or both of these plans at a future Open Enrollment period, you and any dependents enrolled will be subject to a 12-month waiting period on these plans (meaning only preventive and routine services will be covered during the first 12 months of coverage) unless you provide proof of other creditable

SECTION C - DEPENDENT INFORMATION (attach a separate sheet if necessary)

You must report to PPS Benefits within 31 days after a person enrolled as your spouse, domestic partner or dependent child becomes ineligible for benefits. If you make this report on time, the change will be effective the first of the month after your report or the first day of the month after the QSC event occurred. If you do not report this change on time, OEBB may consider that an intentional misrepresentation of a material fact, for which OEBB may terminate the family member's coverage effective the first of the month after eligibility was lost.

Relationship Key: **("Rel Code" below) SP =** Spouse, **DPA =** Domestic Partner **by Affidavit, DPC =** Registered Domestic Partner
CH = Employee and/or Spouse's child, **DPCH** = Domestic Partner's child, **DD** = Disabled Dependent

Ethnicity Key: **H** = Hispanic; **NH** = Non-Hispanic/Non Latino **R** = Refused **U** = Unknown

Race Key: **A =** Asian; **B =** Black/African American; **AI =** American Indian/Alaska Native**; NH =** Native Hawaiian/Other Pacific Islander**;** **W =** White; **R =** Refused; **U =** Unknown

Circle one	Last Name	First Name	MI	Rel Code	Ethnicity	Race	Birth Date	Sex M/F	SS#
Add / Drop									
Add / Drop									
Add / Drop									
Add / Drop									

PPS Use Only: Date MyOebb updated by: PS updated by: Retiree SP: Grade: Annual Salary:

Revised 9/15/11

C.1 Dependent Address (if different than yours. Required if due to Divorce/Separation of Domestic Partnership)

Name: Address:

C.2 Domestic Partner - Check the appropriate box. If covering a domestic partner or partner's children by affidavit, a completed affidavit must be attached or on file in order for benefits to be effective.

☐ Domestic Partner by OEBB Affidavit of Domestic Partnership (attach Affidavit to this form)

☐ Domestic Partner by Oregon Certificate of Registered Domestic Partnership (no copy required unless due to new eligibility)

SECTION D - OTHER GROUP COVERAGE INFORMATION

To receive the cash incentive, you must opt out of medical, dental, and vision and complete this section.

Carrier		
Policy Number	Group Number	Effective Date
Subscriber's Name	Employer	

Medicare Reporting Requirements The following individuals are eligible for Medicare due to age or disability:

☐ No one listed on this form is eligible for Medicare ☐ Self ☐ Spouse or Domestic Partner ☐ Child

Name:________________________ SS#/HICN ___________________ Date Entitled: __________

SECTION E - EMPLOYEE AND SPOUSE OPTIONAL BENEFITS (VARIES ACCORDING TO EMPLOYEE GROUP)

**These benefits are completely voluntary and 100% employee pay. See Additional Paperwork for Explanation of Voluntary Benefits*

NON-REP ONLY -Voluntary Life Insurance

$10,000 - $500,000 Maximum Benefit

☐ **Enroll employee only**

Employees age as of 10/01/2011____________

Total Benefit = $_________________

(Rates are age-graded, See attached form for premiums)

Amounts over $200,000 require evidence of insurability

☐ **Enroll spouse (employee enrollment required)**

Spouses age as of 10/01/2011______________

Total Benefit = $_________________

(Rates are age-graded, See attached form for premiums)

Amounts over $30,000 require evidence of insurability

SEIU ONLY -Voluntary AD&D Insurance*

$10,000 - $500,000 Maximum Benefit

☐ **Enroll employee only**

Amount of benefit (in increments of 10,000)

$______________ Total Benefits

Premium = $0.15 per $10,000 of benefit

☐ **Enroll spouse (employee enrollment required)**

Amount of benefit (in increments of 10,000)

$______________ Total Benefits

Premium = $0.15 per $10,000 of benefit

SECTION F - EMPLOYEE BENEFICIARY-Failure to elect a beneficiary will result in a default election of 'Standard Designation'

☐ I elect the 'Standard Designation'** ☐ I elect a special designation (Please complete The Standard Beneficiary form)

**For more information see http://www.oregon.gov/DAS/OEBB/Standard2009.shtml#Standard_Designation

SECTION G - EMPLOYEE SIGNATURE AND AUTHORIZATION

I declare the dependents listed above and I are eligible for the coverages requested per OEBB Administrative Rule (OAR)-Division 10. I have read and understand OAR-Division 10 concerning Definitions at http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_010.html

I have read and understand OAR-Division 80, Sections 111-080-0040, 111-080-0045 and 111-080-0050 concerning Eligibility and Policy Term Violations and can find this OAR at: http://oregon.gov/OHA/OEBB/docs/DivisionRules/06-2011/PermDiv80_June2011.pdf

I understand I have 31 days to notify my employer of a Qualified Status Change (QSC) which affects eligibility. I have read and understand OAR-Division 40 concerning Enrollment and can find this OAR at: http://oregon.gov/OHA/OEBB/docs/DivisionRules/06-2011/PermDiv40_June2011.pdf

I understand the benefit elections I make are in effect for as long as I continue to meet OEBB's eligibility requirements, or until I elect to change them subject to the provisions of OEBB's plan. I understand I cannot alter my plan selections during the plan year unless I have a QSC; then I am subject to the restrictions of the OEBB QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix at: http://www.oregon.gov/OHA/OEBB/docs/QSCs/QSCMatrix.pdf

I have read the benefit materials and I understand the limitations and qualifications of the OEBB benefits program. If necessary, I authorize premium payments deducted from my pay, unless I self pay premiums. If I self-pay the premiums, I agree to submit monthly payments by the date specified, or my coverage will terminate; I will not be able to reinstate coverage until the next open enrollment period or may lose OEBB eligibility altogether.

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 election supersedes all elections and submissions I previously made for OEBB 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.

_______________________________ _______________________________

Employee Signature Date

Please return this form to: PPS Benefits, BESC 501 N. Dixon Street, Portland, OR 97227. For assistance, call 503-916-3373