2012 Self Pay
Open Enrollment Correction

- Office Use Only -	
Approved by ____	Date_____
Effective Date_________	

Use this form to request a correction to a 2012 enrollment error made during 2011 Plan Change Period.

Not enrolling in a benefit plan for 2012 during Open Enrollment is not a correctable enrollment error. If you did not enroll during Open Enrollment, you cannot make changes to plan election or coverage, including adding dependents to coverage. However, you can elect a different participation status in a PEBB Health Care or Cost Containment Program.

Directions

- **Check the appropriate box in Section 1.**
- **Complete Section 2.**
- **To correct an enrollment error, complete only the section(s) of the form related to that error.** Example: You meant to enroll in Providence Choice but your benefit summary shows that you enrolled in the Statewide Plan. Check the box next to "Providence Choice" in Section 5 and skip to Section 6.
- **To correct a status error in a Health Care or Cost Containment Program *(Health Engagement Model, Tobacco Use, Spousal Other Group Coverage),* complete Section 4.**
- **Complete Section 6. Sign and date the form.**
- **Deliver, mail, or fax the completed, signed form to BenefitHelp Solutions.** Include any other needed documents such as an affidavit, or legal documentation.

Deadlines for correcting enrollment errors

- To correct an enrollment error before 2012 benefits go into effect, you must submit this completed form no later than Dec. 31, 2011. To correct an enrollment error after benefits go into effect, you must submit this completed form no later than Jan. 31, 2012..

Deadlines for avoiding an additional charge based on a status error in a Health Care or Cost Containment Program (Health Engagement Model, Tobacco Use, Spousal Other Group Coverage)

If you are correcting one or more of the programs found in Section 4, PEBB Health Care and Cost Containment Programs, to avoid a billing on your January or February premium statements this form MUST be submitted to BHS office by December 9 or January 9 respectively.

NOTE: If you are correcting your status from non-participant to participant in 2012 Health Engagement Model Program, you must complete your medical plan's Health Assessment by Feb. 15. The correction does not allow an extension.

2012 Self Pay

Open Enrollment Correction

- Office Use Only -	
Approved by ____	Date_____
Effective Date_________	

1. I am

☐ OLCC Agent	☐ Post Doc/J1 Visa	☐ Blind Business Enterprise Employee
☐ Foster Parent (attach copy of Foster Parent Certificate)		☐ Nurse working less than half time

1.a Check the appropriate box

☐ I am submitting this form to correct an error I made in enrolling in a benefit plan. (Complete only the sections related to your enrollment error, along with Sections 1, 2 and 6.)

☐ I am submitting this form to correct my status in a Health Care or Cost Containment Program. (Complete only Sections 1, 2, 4 and 6).

2. Contact Information

You must complete all fields.

PEBB Benefit Number (P########),

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

BHS 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)	Work Phone	Home Phone….(optional)

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 ☐ 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	☐	

3. Dependent Information

List only dependents you are adding, adding back, or removing from coverage (Term) as a correction to your enrollment. Attach separate sheet if

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*)

necessary. If your dependent has a different contact address, complete section 3.a.

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

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

# from sec.4	Dependent's Residence Address	City	State	Zip/Country Code

3.b If you listed a Domestic partner, indicate the type of Domestic Partnership

☐ By PEBB Affidavit*

☐ By Registered Certificate of Domestic Partnership for same sex individuals. (Copy not required)

3.c *Affidavit Information

Affidavit is for an eligible employee and an individual of the opposite sex, or of the same sex without a Certificate of Registered Domestic Partnership. If you are adding domestic partner or a child by affidavit, you must submit the enrollment form, affidavit, and any required documentation to BHS within the allowed time, or your enrollment will not occur.

4. PEBB Health Care and Cost Containment Programs

Benefits offered by the Public Employees' Benefit Board include programs to improve member health and contain costs. You must select your status in the following programs:

4.a Health Engagement Model (HEM) Program. Members who participate in this program will pay less for their health care benefit. Spouse or domestic partner participation is attached to the employee's status (see the HEM Agreement on page 7).

4.b Tobacco Use Program. Members and spouses or domestic partners who don't currently use tobacco will pay less for their heath care benefit.

4.c Other Employer Group Coverage Program. Members will pay less for their health care benefit if their spouse or domestic partner enrolls in other employer group coverage if it's offered by the spouses' or domestic partners' non Oregon state agency employer.

4.a Select your Status in the HEM Program

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

agreement on page 7).

When you elect not to participate in the HEM Program, the following amounts will be added to your monthly premium for the 2012 plan year: HEM applies to the subscriber and their spouse or domestic partner.

- 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.

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 added to your monthly premium 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 enrolled 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 added to your monthly premium 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 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.

5. Medical and Dental Plans

Choose your benefit election and plan. Blind Business Enterprise agents may enroll in a medical plan, only. All other self-pay participants may enroll in medical and dental plans. You must enroll in a medical plan to enroll in a dental plan.

Medical Plan (select one)	Full-Time	Part-time
PEBB Statewide Plan	☐	NA

Dental Plan (select one)	Full Time	Part Time
Kaiser Permanente	☐	NA

Kaiser Permanente HMO	☐	NA
Kaiser Deductible	☐	NA
Providence Choice	☐	NA
☐ **Continue current medical and dental plans for 2012**		

ODS Traditional	☐	NA
ODS Preferred	☐	NA
Willamette Dental	☐	NA

6. Participant 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.

____ ____________________

Participant Signature Date

Send to:	**BenefitHelp Solutions** PO Box 67240 Portland, OR 97268-1240	Portland (503) 765-3581 Toll-free (800) 556-3137 Toll-free Fax (888) 393-2943

Keep a copy of all benefit documents 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.