



Life And Disability Enrollment Form

Active Employee

2007 Plan Year

Instructions



Enroll online at <https://pebb.benefits.oregon.gov/members>

Complete this form to enroll in life, accidental death and dismemberment, and/or disability coverage through PEBB as a newly hired employee and to enroll or make a change in coverage during Open Enrollment. **If you are enrolling your domestic partner for optional life or dependent life insurance coverage a completed Affidavit of Domestic Partnership must be attached or on file at your agency.**

SECTION A – EMPLOYEE INFORMATION

- Complete all items in this section.

SECTION B – LIFE INSURANCE, AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Check the box of next to the plan(s) you are selecting.

- **Dependent Life Coverage.** Coverage amount is \$5,000 for all eligible dependents.
- **Optional Life for Employee and Spouse or Domestic Partner Coverage.** The amount you choose must be in increments of \$20,000, up to a maximum of \$400,000 per individual.
 - **Newly Eligible** – When you enroll within the first 60 days of your eligibility or hire date you and your spouse or domestic partner qualify for \$20,000 of **Guarantee Issue** optional life coverage. This means that you may enroll for \$20,000 of coverage per individual and you do not need to complete the Medical History Statement.
 - **Newly Eligible** – When you enroll within the first 60 days of your eligibility or hire date and **you want more than \$20,000** optional life coverage for you, your spouse, or domestic partner you must complete a Medical History statement.
 - **Open Enrollment** – You must complete a Medical History Statement.
- **Accidental Death & Dismemberment (AD&D) Coverage.** Check the appropriate boxes in the Coverage Tier and Coverage Choice sections.

SECTION C – DISABILITY INSURANCE

- If this is a new enrollment for Short or Long Term Disability coverage, check the **New Coverage** box under **Coverage Type** for each of the disability plans you select.
- To cancel either disability coverage check the **Cancel Coverage** box under **Coverage Type**.
- If you are enrolling for Long Term Disability coverage, check a box under **Waiting Period - Coverage Level**.
- To change your current Long Term Disability coverage level, check the **Change in Coverage** box under **Coverage Type**. Also, select a new **Waiting Period – Coverage Level**.

SECTION D – BENEFICIARY DESIGNATION

- For Spouse or Domestic Partner Optional Life and Dependent Life coverage, you are automatically the beneficiary.
- For Life and AD&D coverage, you may select the Standard Designation or designate specific beneficiaries.
- If you designate specific primary beneficiaries, you may also list contingent beneficiaries. The total of all beneficiary percentages per primary or contingent must equal 100%.
- You may complete or change your beneficiary designation online at anytime at <https://pebb.benefits.oregon.gov/members>

SECTION E – EMPLOYEE SIGNATURE AND AUTHORIZATION

- Read this section carefully. Sign and date the form.
- Make a copy for your records.
- Submit the completed form to your agency or university benefits office.

Send the Medical History Statement directly to The Standard Insurance Company at the address shown on the statement.



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All previous coverage selections will continue unless you cancel them. If you are enrolling your domestic partner for optional life or dependent life insurance coverage a completed Affidavit of Domestic Partnership must be attached or on file at your agency.

SECTION A - EMPLOYEE INFORMATION

<input type="checkbox"/> NEW EMPLOYEE HIRE DATE :		<input type="checkbox"/> OPEN ENROLLMENT	
LAST	FIRST	MI	ID NUMBER (SSN, OUS#, Benefit #)
DATE OF BIRTH (MM-DD-YYYY)	GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		
RESIDENCE ADDRESS <input type="checkbox"/> New Address	CITY	STATE	ZIP
	COUNTY	HOME PHONE	
MAILING ADDRESS (if different from above) <input type="checkbox"/> New Address	AGENCY	WORK PHONE	
EMAIL			

SECTION B - LIFE INSURANCE and ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Required Basic Life Insurance, \$5,000: Enrollment in the Basic Life Insurance is automatic when you enroll in medical and dental elections.

Dependent Life: \$5,000 spouse/partner and children. You do not need to enroll your eligible dependents in any PEBB plans for them to be eligible for this coverage.

New Coverage Cancel Coverage

Employee Optional Life: (\$20,000 increments to \$400,000)

New Hire Options:

- Guarantee Issue - \$20,000 only
- Total Requested Amount: \$ _____ *
- (include any existing coverage)

Open Enrollment Options:

- Change Coverage: From \$ _____ to \$ _____ TOTAL*
- (include any existing coverage)
- Cancel Coverage

***Medical History statement is required-see form instructions**

Spouse or **Domestic Partner Optional Life:** (\$20,000 increments to \$400,000)

Spouse/Partner's Name: _____ **ID# (SSN, University ID, Benefit Number):** _____

Date of Birth: _____

New Hire Options:

- Guarantee Issue - \$20,000 only
- Total Requested Amount: \$ _____ *
- (include any existing coverage)

Open Enrollment Options:

- Change Coverage: From \$ _____ to \$ _____ TOTAL*
- (include any existing coverage)
- Cancel Coverage

***Medical History statement is required-see form instructions**

Accidental Death & Dismemberment (AD&D): (\$50,000 increments to \$500,000)

Coverage Tier:

- Employee Only
- Employee and Dependents

Coverage Choice:

- New Coverage (indicate amount) \$ _____
- Change Coverage Amount From \$ _____ to \$ _____
- Cancel Coverage

SECTION C - DISABILITY INSURANCE

Short Term Disability

Long Term Disability

Coverage Type:

- New Coverage
- Cancel Coverage

Coverage Type:

- New Coverage
- Change in Coverage
- Cancel Coverage

Waiting Period - Coverage Level

- 90 day - 60%
- 90 day - 66 2/3%
- 180 day - 60%
- 180 day - 66 2/3%

SECTION D - BENEFICIARY DESIGNATION

- Select one:
- I elect the standard designation* with no beneficiaries listed.
 - I designate the following beneficiary(ies)

Name of Beneficiary or Trust	DOB	Relationship	Primary or Contingent	Percentage
			<input type="checkbox"/> <input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	

* The standard designation creates a chain of beneficiaries that automatically allows for future marriages, divorces, births, deaths, or adoptions within your family as established by Oregon law.

Attach additional sheet if necessary to list more names.

SECTION E - EMPLOYEE SIGNATURE AND AUTHORIZATION

I acknowledge and understand PEBB insurance carriers may request or disclose information about me or my enrolled dependents from time to time for the purpose of facilitating insurance payments; or for the purpose of business operations necessary to administer employee benefits; or as required or allowed by law. Information may be related to treatment or services performed by a health care practitioner, dentist, pharmacist, hospital, or other institution providing healthcare, or an insurance carrier or group plan. I understand the benefit elections I have made on this form are in effect, as long as eligibility requirements are met, until I elect to change them, subject to the provisions of each plan. I have read the benefit materials and understand the limitations and qualifications of the PEBB benefit program. I authorize premium payments to be deducted from my pay. This authorization will remain valid until I sign and submit a new or updated Life and Disability Enrollment Form within the provisions of the benefit program.

Employee Signature

Date

PEBB Use Only R09/06

Approved by (initials):

Date:

Approved change effective date:

PDB updated by (initials):