

PHIP Request for Disenrollment

Per OAR 459-035-0080 (2)(a) disenrollment from your PERS Health Insurance Program (PHIP) health plan will be effective at the end of the month in which a signed notification is received by PHIP from the covered person to terminate coverage (unless a later date of disenrollment is requested).

Your requested disenrollment date: ____ / ____ / ____	SSN/PERS ID#:
Please terminate coverage for: ☐ Retiree ☐ Spouse/DDP only ☐ Dependent Child(ren) only	

PERS Retiree	First Name	MI	Medical Only	Dental Only	All Coverage
Last Name			☐	☐	☐

List spouse/DDP and each dependent child to be disenrolled:

Last Name	First Name	MI	Spouse/DDP or Dependent	Medical Only	Dental Only	All Coverage
			Spouse/DDP ☐	☐	☐	☐
			Dependent ☐			
			Spouse/DDP ☐	☐	☐	☐
			Dependent ☐			

Select the coverage you wish to disenroll from:

Medicare Plans		
☐ Kaiser Permanente Senior Advantage	☐ Moda Health Supplement Plan	☐ UnitedHealthcare® Group Medicare Advantage (PPO)

Non-Medicare Plans	Dental Plans
☐ Kaiser Permanente Core Value or HDHP	☐ Kaiser Permanente Dental
☐ Moda Health Choice Core Value or HDHP	☐ Delta Dental Plan of Oregon

Reason for disenrollment (required)		
☐ Plan Change (From October 1 – November 15 Only)	☐ Gained other coverage	☐ Death
☐ Other		

Sign and Date Prior To the Requested Disenrollment Effective Date

Retiree Signature/Power of Attorney Signature X	Today's Date
Spouse/DDP Signature X	Today's Date
Dependent Child Signature (<i>if over 18 years old</i>) X	Today's Date

Please attach legal documentation if you are the legal guardian or Power of Attorney.

Once disenrollment has occurred, you cannot re-enroll unless you experience a new enrollment opportunity. For eligibility and enrollment information, visit pershealth.com.

