PERS
HEALTH
INSURANCE PROGRAM
Public Employees Retirement System

PHIP Enrollment Request Form

Please contact PHIP if you need information in another language or format (e.g. braille).

Enrollment
OAR 459-035-0070
A completed PHIP Enrollment Request Form must be submitted when you are initially enrolling, adding a dependent or making a change to your PHIP coverage, either at plan change (Plan Change Period, Snow Bird Option, moving out-of-area) or due to a family status change. Signature is required by all enrollees over the age of 18.

Completed Enrollment Request Form
OAR 459-035-0080
In order to avoid a gap in coverage or forfeiting your enrollment opportunity, please submit all requested information/documentation with the completed Enrollment Request Form prior to your requested effective date.

If your Enrollment Request Form is missing information or additional documentation, your application will be considered **incomplete. If you are unable to provide the necessary information and/or documentation prior to your requested effective date, your effective date will change to the first of the next month.**

Effective Date of Coverage
OAR 459-035-0080
The effective date of coverage is the first of the month of the enrollment opportunity (i.e., PERS retirement, loss of employer coverage or initial Medicare eligibility) if the completed application is received in advance of the enrollment opportunity. Applications received after the enrollment opportunity will go into effect the first of the month after the completed application is received. Members that submit their application at the end of their enrollment timeline could have a gap in coverage or lose their enrollment opportunity if the completed application is received outside of the PHIP enrollment opportunity.

If your Enrollment Request Form is missing information or additional documentation, your application will be considered incomplete.

Please retain a copy for your records and mail any attachments along with the original Enrollment Request Form to:

PERS Health Insurance Program
P.O. Box 231299, Tigard, Oregon 97281-1299
Phone: 503-224-7377 or 800-768-7377. TTY users call 711.
Fax: 503-765-3452 or 888-393-2943

PHIP Enrollment Request Form Instructions

Please fill out the form in its entirety; keep a copy for your records. Please remember if your Enrollment Request Form is missing information or additional documentation, your application will be considered incomplete. DO NOT STAPLE.

Section A — Information About You

- Your requested PHIP enrollment date: The effective date of coverage is the first of the month of the enrollment opportunity (i.e., retirement, loss of employer coverage or initial Medicare eligibility) if the completed application is received in advance of the enrollment opportunity. Applications received after the enrollment opportunity will go into effect the first of the month after the completed application is received.
- Fill out all of the information related to the PERS retiree.
- List all individuals that will be enrolled under the PHIP coverage with the retiree. If a non-PERS dependent is already enrolled, you still need to include them as a dependent on this enrollment form so that they can be matched up with your enrollment.
- **Ensure all necessary documents are provided as required. The following documents may be required to enroll your spouse/dependent for your Enrollment Request Form to be complete:**
  - Birth certificate or adoption notice for dependents under age 26.
  - Necessary documentation for dependents over age 26 as required by the health plan.
  - Marriage certificate if the spouse has a different last name from the retiree.
  - Affidavit of Domestic Partnership and most recent tax filings for dependent domestic partner (DDP).
  - If enrollment reason is due to group coverage ending, proof of 24 months of continuous employer-sponsored coverage (Creditable Coverage Letter).
  - Any other documentation needed to confirm enrollment per PHIP guidelines.
- Choose the reason for this enrollment.
  - If making a change at plan change, choose the plan change only box that coincides with which benefits you are changing (medical & dental plan change, medical only plan change, dental only plan change).
  - A Disenrollment Form must also be submitted any time you are requesting a plan change (Plan Change Period, Snow Bird Option, moving out-of-area).
- **Individuals experiencing homelessness.**
  - If you want to join a plan but have no permanent residence, a Post Office box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent resident address.

Section B — Medicare Information

- Fill out the Medicare information for all individuals that are eligible for Medicare. Medicare enrollees must be enrolled in both Medicare Part A and Part B, and a copy of the Medicare card or a Letter of Entitlement must be provided in order for processing to be completed.
  - **If proof of Medicare Part A and Part B (copy of your Medicare card or Letter of Entitlement) is not received prior to your requested effective (enrollment) date in Section A, your application may be considered incomplete per the Centers for Medicare and Medicaid Services (CMS) and your application will be denied.** You will be required to submit a new Enrollment Request Form and your effective date of coverage will be the first of the month after your newly completed Enrollment Request Form is received. This could cause a gap in coverage.

Section C — Choose Your Medical Plan

- Choose the medical plan within the health plan's enrollment service area you permanently reside in.
  - If you are Medicare eligible, you can only enroll in one of the available Medicare plan options.
  - If you are not yet Medicare eligible, you can choose from either a traditional non-Medicare Core Value plan or a HSA-qualified High Deductible Health Plan. Once enrolled in the Qualified HDHP plan, you cannot switch to the Core Value plan at any time in the future.

Section D — Choose Your Dental Plan

- To enroll in a PHIP dental plan, you must enroll during the same enrollment opportunities as the PHIP medical plan.
- If you are enrolling in a dental plan you can choose either Delta Dental Plan of Oregon or Kaiser Permanente dental.
  - You must live within the Kaiser Permanente service area in order to choose Kaiser Permanente dental.
- You may choose either dental plan, regardless of the medical plan you choose, as long as you live within the appropriate service area.
- There may be a 12-month waiting period for some services if you have not had 12 months of continuous dental coverage immediately preceding enrollment into the PHIP Delta Dental of Oregon plan.
- If not selecting a dental plan, you must check that you do not want dental coverage under Section D.

Section E — Payment Options

- Select one payment option for how you want to pay your monthly PHIP premiums.
  - If pension deduction is chosen, the pension holder will need to authorize by signing and dating this option.
  - If adding a new spouse or dependent, the enrolled PERS retiree must authorize the new pension deduction amount by signing and dating this payment option.
  - A voided check is needed if Electronic Funds Transfer (EFT) has been chosen.

Section F — Please Read And Answer These Important Questions

- Answer all important questions on page 5 of the Enrollment Request Form.

Section G — Release Of Information

- Read the Release Of Information statement.

Section H — Lock-In

- Read the Lock-In statement.

Section I — I Agree To The Following

- Read the I Agree To The Following section.

Section J — Sign Here – Signature Required by All Enrollees

- You, your spouse, and dependent child (over age 18 only), if enrolling, must sign and date the Enrollment Request Form.
  - The date must be prior to the effective (enrollment) date noted on Page 1 of the application.
  - If an individual is being added to coverage that is already established under PHIP (i.e., spouse is now Medicare eligible), only the enrolling party needs to sign the form.
  - **The receipt date, not the date the application is signed, will establish the effective/enrollment date.**

Section K — Authorization to Disclose Protected Health Information

- Fill out the optional Authorization to Disclose Protected Health Information (PHI) if you would like someone to be able to contact PHIP and obtain information on your behalf.
  - This form is optional and can be completed at a later date.
  - The maximum duration for the authorization is 24 months and must be submitted again upon expiration of the previous document.

OFFICE USE ONLY						
	PHIP approved effective date:	Member ID #:		SEP (type):	Not eligible:	Plan #:
		Effective date of coverage:		PBP:		Premiums:
	Final received date:	ICEP/IEP:	AEP:	Benefit Plan:		Group #:
		Subgroup ID:		Retdate:		YOS:
	Dependent Subgroup ID::			Dependent Benefit Plan:		◯ OPSRP ◯ RHIA/RHIPA ◯ EWEB

Section A Information About You

Requested Effective Date of Coverage (must be first of the month) _____/_____/_____				
PERS Retiree Last Name		First		MI
SSN	PERS ID# (optional)	Date of Birth	Sex ◯ M ◯ F	Medicare Eligible ◯ Yes ◯ No

Select all individuals to enroll

☐ Retiree ☐ Spouse ☐ Dependent Domestic Partner (DDP) ☐ Dependent Child/Children

☐ Spouse/DDP is currently enrolled in PHIP ☐ Spouse/DDP is a PERS retiree	Spouse/DDP's SSN	Spouse/DDP's PERS ID#

Spouse/DDP Last Name		First		MI
SSN	Date of Birth		Sex ◯ M ◯ F	Medicare Eligible ◯ Yes ◯ No
Dependent Child Last Name		First		MI
SSN	Date of Birth		Sex ◯ M ◯ F	Medicare Eligible ◯ Yes ◯ No

☐ *If additional dependents, please attach a separate sheet.*

New Member Enrollment

☐ New PERS retiree
- ☐ PERS Disability Approval Letter *(include copy)*
- ☐ PERS Disability Intent to Deny *(include copy)*

☐ Medicare eligible

☐ Other: _____

☐ Snow Bird option ☐ Moving out-of-area

☐ New dependent *Date:* _____

☐ Group coverage ending *Date:* _____

☐ EWEB Retiree

Plan Change (during Oct. 1 - Nov. 15 each year for existing PHIP members only)

◯ Medical & dental plan change ◯ Medical only plan change ◯ Dental only plan change

Permanent Resident Address ***(not a P.O. Box)***	City	State	ZIP
County	Home Phone Number	Alternate Phone Number	
Mailing Address ***(if different; P.O. Box accepted)***	City	State	ZIP
Email Address*			

**By including your email address you are allowing PHIP permission to use your email for PHIP related surveys, newsletters, and other important materials within accordance to PHIP's privacy policy.*

Section B Provide Your Medicare Insurance Information

YOU MUST HAVE Medicare Part A and Part B in order to enroll in a PHIP Medicare plan (Required if Medicare eligible). If unable to provide a copy of your entitlement information your PHIP application may be considered incomplete.

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card AND
- Attach a copy of your Medicare card or your letter from: Social Security or the Railroad Retirement Board.

Retiree's Information

Name (as it appears on your Medicare card): _____

Medicare Number: _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Spouse/Dependent Information

Name (as it appears on your Medicare card): _____

Medicare Number: _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Section C Choose Your Medicare Plan

Medicare family members must enroll under the same health plan

Select all individuals enrolling in a Medicare Plan

☐ Retiree ☐ Spouse ☐ Dependent Domestic Partner (DDP) ☐ Dependent Child/Children

Medicare plans — Includes Medicare Part D Prescription Program

◯ Kaiser Permanente Senior Advantage (Traditional copay plan)* *with PERS Kaiser Rx*	◯ Moda Health Medicare Supplement Plan *with Moda Health Rx (PDP)*	◯ Providence Medicare Align Group Plan + RX (HMO)* *with PERS Providence Rx* ◯ Providence Medicare Flex Group Plan + RX (HMO-POS)* *with PERS Providence Rx*	◯ UnitedHealthcare® Group Medicare Advantage (PPO) plan *with PERS UnitedHealthcare Rx*

*A Health Plan with a Medicare contract

Section C Choose Your Non-Medicare Plan *(If applicable)*

Non-Medicare family members must enroll under the same health plan

Select all individuals enrolling in a Non-Medicare Plan

☐ Retiree ☐ Spouse ☐ Dependent Domestic Partner (DDP) ☐ Dependent Child/Children

Non-Medicare plans — All plans include prescription drug coverage.	
◯ Kaiser Permanente Traditional Core Value *(no deductible)*	◯ UnitedHealthcare® Choice Plus Core Value *($1,000 deductible)*
◯ Kaiser Permanente Qualified High Deductible Health Plan (HDHP)*	◯ UnitedHealthcare® Qualified High Deductible Health Plan (HDHP)*

Once enrolled in the Qualified HDHP plan, you cannot switch to the Core Value plan at any time in the future.

**PHIP qualified High Deductible Health Plans can be used with a Health Savings Account (HSA). Contact your tax advisor for specific rules regarding HSA's.*

Section D Choose Your Dental Plan *(Select only one dental plan)*

◯ Kaiser Foundation Health Plan of the NW ◯ Delta Dental of Oregon

◯ I do not want dental coverage

Have you and/or dependents had continuous employer-sponsored dental coverage for the last 12-months?

Retiree: ◯ Yes ◯ No Spouse/DDP: ◯ Yes ◯ No Dependents: ◯ Yes ◯ No

Name of previous dental carrier: _____

Plan#: _____

ID#: _____ Phone number: _____

You must be enrolled in a PHIP medical plan to enroll in PHIP dental plan.

Section E Payment Options

Payment selection will remain in effect until PHIP has received written notification to update.

Select only one payment option:

○ **Option 1: Pension Deduction**

Description: *The monthly health insurance premium is automatically deducted from the PERS retiree's monthly pension check. To choose this option, your pension must be sufficient to cover the entire monthly premium; partial premiums cannot be deducted.*

I hereby authorize the PERS Health Insurance Program to deduct my monthly premiums for medical and/or dental insurance from my monthly PERS pension benefit. **I also understand that it may take up to 90 days for the premiums to begin deducting. In order for my health insurance to be kept current, I will receive a monthly invoice and be responsible for remitting payment by the first of each month until the deduction begins.**

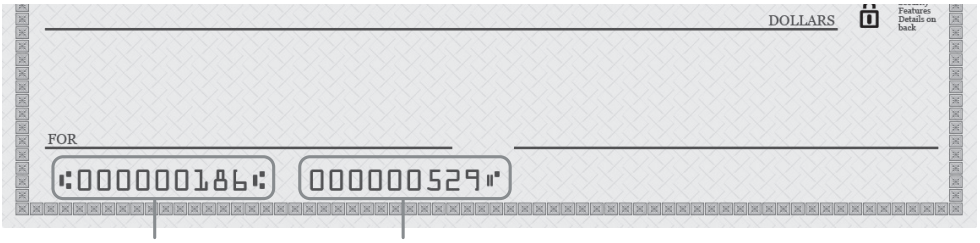
Pension Holder's Signature X	SSN	Signature Date

○ **Option 2: Electronic Funds Transfer (EFT) — Attach a voided check if deducting from checking account.**

Description: *The monthly health insurance premium is electronically deducted from the checking or savings account at the beginning of each month.*

I authorize the PERS Health Insurance Program to deduct my monthly premiums for medical and/or dental insurance from the account specified below. I understand I can cancel these deductions by submitting a written request to PERS Health Insurance. If PHIP is unable to pull the funds as directed, EFT will be suspended and I will be notified. **I also understand that it may take up to three weeks for the premium deductions to take effect. If the deduction does not occur by the first of the month, a catch-up deduction will take place on the 15th of the month. After the catch-up pull, deductions will occur regularly on the first of each month.**

Bank Name	Routing No.	Account No.



9-digit routing no. *Account no.*

Account Holder's Signature X	SSN	Signature Date

Section F Please Read And Answer These Important Questions

Medicare only

1. Are you enrolled in your state Medicaid program?
   a. Retiree: ◯ Yes ◯ No
   b. Spouse/DDP: ◯ Yes ◯ No
   c. Dependent Child: ◯ Yes ◯ No

Medicare and Non-Medicare

2. Are you a resident of a long-term care facility, such as a nursing home, adult foster home, or assisted living facility?
   a. Retiree: ◯ Yes ◯ No
   b. Spouse/DDP: ◯ Yes ◯ No
   c. Dependent Child: ◯ Yes ◯ No

If YES, please list the name of the facility: _____

Phone number: _____ Address: _____

City: _____ State: _____ ZIP: _____ Date of admission: _____ / _____ / _____

3. Will you (or your spouse/DDP/dependent) have other coverage in addition to your PHIP coverage?
   a. Medical plan ◯ Yes ◯ No
   b. Prescription drug plan ◯ Yes ◯ No

If YES, please list your other coverage and your identification (ID) number(s) for this coverage:

Retiree Name of other coverage: _____ ID# for this coverage: _____

Spouse/DDP/Dependent Name of other coverage: _____ ID# for this coverage: _____

Optional

Retiree Primary Care Provider (First and last name): _____

Established patient? ◯ Yes ◯ No

Spouse/DDP/Dependent Primary Care Provider (First and last name): _____

Established patient? ◯ Yes ◯ No

Section G Release Of Information

By joining the PHIP Medicare or non-Medicare health plan, I acknowledge that the Medicare or non-Medicare health plan will release my information to Medicare or other plans as is necessary for treatment, payment and health care operations.

Section H Lock-In

I understand that beginning on the date my Kaiser Permanente Senior Advantage, Kaiser Permanente non-Medicare Traditional Core Value and qualified HDHP plans or Providence Medicare Align Group Plan + RX (HMO) plan begins, all enrolled members will receive all of their health care from, or have authorized their plan's contracted providers, with the exception of emergency or urgently needed services or out-of-area dialysis services. (Refer to your health plan to determine coverage for emergency and urgently needed services, out-of-area dialysis services, and travel benefits.)

I understand that the Moda Health Medicare Supplement, Providence Medicare Flex Group Plan+Rx (HMO-POS), or UnitedHealthcare Group Medicare Advantage (PPO) plan and UnitedHealthcare non-Medicare Select Plus Core Value and qualified HDHP plans allows me to see any provider of my choice. (Excess charges may apply when using providers outside of the network.)

Section I I Agree To The Following

By completing this enrollment application, I agree to the following:

Medicare only

1. I will maintain my Medicare Part A and Part B coverage.
2. I can only be enrolled in one Medicare Advantage and/or one Part D Prescription Drug plan at a time. I understand that my enrollment in the PHIP plan will automatically end my enrollment in another Medicare Advantage or another Part D Prescription Drug plan.
3. It is my responsibility to inform PHIP of any other health or prescription drug coverage that I have or may get in the future.
4. As a Medicare enrollee, I understand that I may disenroll from this plan only at certain times of the year, or under certain circumstances, by sending a written request to PHIP.

Medicare and Non-Medicare

5. Enrollment in this plan is generally for the entire calendar year.
6. If I move out of my health plan's service area, I will notify PHIP within 30 days, so I can disenroll and find a new PHIP plan in my new area.
7. I have the right to appeal my health plan decisions about benefit payment or services.
8. I understand that if I currently have health insurance coverage from another employer or union plan, joining a PHIP plan could affect my current employer or union health benefits. Contact your current group benefit administrator for questions about how your current coverage might be affected.
9. If I am assessed a Part D Income Related Monthly Adjustment Amount (Part D-IRMAA), I will be notified by the Social Security Administration. I understand that I will be responsible for paying this extra amount in addition to my plan premium in order to maintain PHIP coverage. I will either have the amount withheld from my Social Security benefit check or be billed directly by Medicare or Rail Road Board (RRB). DO NOT pay PHIP the Part D-IRMAA.
10. I understand premium rates are subject to change, at any time as required by Medicare due to Medicare imposed penalties or assessments, such as Medicare Part D Late Enrollment Penalty or Low Income Subsidy (Extra Help) notifications.
11. I will read the Member Handbook or Evidence of Coverage (EOC) document from my plan when I receive it to know which rules I must follow to get coverage with this plan. I understand Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
12. I understand it is my responsibility to review all PHIP member materials and understand my obligation as a PHIP member.

Section J Sign Here — Signature Required By All Enrollees (Retiree, Spouse/DDP, and/or Dependent Child)

I understand that my signature or the signature of the person authorized to act on my behalf under the laws of the State where I live on this enrollment form means that I have read and understand the contents of this form. Previously enrolled medical and/or dental plans with PHIP will be terminated in accordance with any medical and/or dental plan changes associated with this enrollment form upon the PHIP approved effective date. Medicare members agree to keep their Medicare Part A and Part B coverage current and to inform PHIP of any other health or prescription drug coverage that they have or may get in the future. Medicare members agree that they can only be enrolled in one Medicare Advantage and/or Part D Prescription Drug plan at a time.

I also acknowledge that PHIP will release my eligibility and health-care information, including my prescription drug event data to Medicare or other plans, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

The information on this Enrollment Request Form is correct to the best of my knowledge. I understand if I intentionally provide false information on this form, I may be disenrolled from the PHIP health plan I have chosen.

Retiree Signature X	*Today's Date
Spouse/DDP Signature X	*Today's Date
Dependent Child Signature *(if over 18 years old)* X	*Today's Date

If signed by an authorized individual (as described above) this signature certifies that:

1. This person is a parent or guardian for dependent child(ren);
2. This person is authorized under State law to complete this enrollment; and
3. Documentation of this authority is available upon request by the health insurance plan, PHIP or Medicare. Please complete the following information and attach proof of Legal Guardian, Power of Attorney, or proof of authorization by State law.

Forms Completed By (Name)**	Signature X	
Relationship to Enrollee		
National Producer Number (Agents/Brokers only):		
Address	Phone no.	*Today's Date

**Form must be dated prior to effective date, no more than 90 days.*
***Please attach legal documentation if you are the legal guardian or holder of Power of Attorney.*

For individuals helping PERS member with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Phone #: _____

Relationship to PERS member: _____

Signature: X _____ Date: _____

National Producer Number (Agents/Brokers only): _____

Section K Authorization To Disclose Protected Health Information (PHI) *(optional)*

Purpose: This authorization allows the PERS Health Insurance Program (PHIP) to discuss your **retirement date and years of PERS pension service, health plan enrollment, date of enrollment, disenrollment with your health plan and billing/premium information** with the individual identified below. Each person enrolled who wants to share this information must complete a separate authorization. You can find more authorization forms at pershealth.com. ***You must complete all fields below.*** This authorization does not provide the same rights afforded with Power of Attorney documentation.

I authorize: Representatives of the PERS Health Insurance Program and my health plan:

☐ Moda Health Plan, Inc. ☐ Kaiser Foundation Health Plan of the NW ☐ UnitedHealthcare®

☐ Providence Health Assurance *(Additional PHI forms may be required by your selected health plan)*

To obtain and disclose my Protected Health Information (PHI) to:

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Information obtained or disclosed with this authorization will be limited to the minimum information needed to achieve the purpose defined above.

I have the right to revoke this authorization in writing at any time. If I revoke this authorization, the information described above will no longer be disclosed for the reasons covered by this written authorization. Any previously disclosed information made with my permission cannot be taken back and may be subject to redisclosure and no longer protected by federal law.

This authorization shall be in force and in effect until the following date: _____
Not to exceed 24-months from the signature date. If the date field is left blank, the authorization will expire 24-months from the signature date.

I have reviewed and understand this authorization:

PHIP Member Name	SSN and/or PERS ID#
Signature X	Today's Date

OR

PHIP Member's Representative Name*	
Address	Phone #
Signature X	Today's Date
Relationship to Member: ☐ Parent ☐ Legal guardian ☐ Power of Attorney	

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

To change or revoke this authorization, please send a written statement to: PERS Health Insurance Program, P.O. Box 231299, Tigard, Oregon 97281-1299