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).

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

- If you are enrolling in a dental plan you can choose either Delta Dental 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 employer-sponsored dental coverage immediately preceding enrollment into the PHIP Delta Dental of Oregon.
- If not selecting a dental plan you must check that you do not want dental coverage under Section D.

Section E — Payment Options

- Select the 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 *(optional)*

- Fill out the 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.

Mail completed form to: PERS Health Insurance Program, P.O. Box 40187, Portland, Oregon 97240-0187