2016-17 Plan Year
New Enrollment Form

Entity Use Only	
OEBB	
Lawson	
Effective Date	

Use this form to enroll in plans as a newly benefit eligible employee. Plan elections will be active on your first day of employment in a benefit eligible position, unless you are requesting coverage that requires carrier approval. Carrier approval coverage will go into effect the first of the month following carrier approval.

1. Member Information

Last Name	First Name		MI
Employee ID / Social Security Number	Gender ☐ Male ☐ Female		Date of Birth (mm-dd-yyyy)
Home Phone	Work Phone	Personal Email	
☐ Check if new address	Work Email		
Address			Apt or Space #
City	State	Zip	County

Medicare Eligible? ☐ Yes ☐ No **Are you serving or did you ever serve in the military?** ☐ Yes ☐ No

If "Yes," do you authorize OEBB to send your name and address to the Oregon Department of Veterans' Affairs (ODVA) for the purpose of receiving benefit information? ☐ Yes ☐ No

Ethnicity (Select One): ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race (Select at least one. If selecting more than one, circle one as primary):
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Employment Type: ☐ Classified ☐ Licensed ☐ MAPS **FTE:** ☐ Full-Time ☐ Part-Time

2. Tobacco Usage (Responses in this section are required)

MEMBER **In the last 12 months (Select one):**	SPOUSE/DOMESTIC PARTNER **In the last 12 months (Select one):**
☐ I have used tobacco products ☐ I have ***not*** used tobacco products ☐ I have never used tobacco products	☐ I do not currently have a spouse/domestic partner ☐ My spouse/domestic partner has used tobacco products ☐ My spouse/domestic partner has ***not*** used tobacco products ☐ My spouse/domestic partner has never used tobacco products

3. Dependent Information (Attach additional sheets if necessary)

You must report to OEBB within 31 days after a person enrolled as your spouse/domestic partner or dependent child becomes ineligible for benefits. If you do not report this change on time, OEBB may consider that an intentional misrepresentation of a material fact, for which OEBB may terminate the family members' coverage effective the first of the month after eligibility was lost.

If listing a Domestic Partner as a dependent, indicate the type of Domestic Partnership*:
☐ By OEBB Affidavit of Domestic Partnership* ☐ By Registered Certificate (Copy not required)

*Affidavit Information: If you are adding a domestic partner by OEBB Affidavit, you must submit the affidavit to OEBB within five business days of this enrollment or the individual's coverage will not be effective. OEBB's Affidavit of Domestic Partnership can be found online at: http://www.oregon.gov/oha/OEBB/pages/Forms.aspx

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DEPENDENT A ☐ Change Enrollment ☐ Remove Dependent

☐ Enroll ☐ Remove
☐ Medical ☐ Vision ☐ Dental

Relationship to Member: ☐ Spouse ☐ Domestic Partner	Child of: ☐ Member/Spouse ☐ Domestic Partner	Overage Disabled Dependent of: ☐ Member/Spouse ☐ Domestic Partner

Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy)	Social Security, HICN, or Tax ID Number:	Medicare Eligible? ☐ Y ☐ N

Last Name	First Name	MI

Address (if different from Member address)	City	State	Zip

Ethnicity (Select One):
☐ Hispanic ☐ Non-Hispanic/Latino
☐ Refused ☐ Unknown

Race (Select at least one. If selecting more than one, circle one as primary):
☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Refused
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown

DEPENDENT B ☐ Change Enrollment ☐ Remove Dependent

☐ Enroll ☐ Remove
☐ Medical ☐ Vision ☐ Dental

Relationship to Member: ☐ Spouse ☐ Domestic Partner	Child of: ☐ Member/Spouse ☐ Domestic Partner	Overage Disabled Dependent of: ☐ Member/Spouse ☐ Domestic Partner

Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy)	Social Security, HICN, or Tax ID Number:	Medicare Eligible? ☐ Y ☐ N

Last Name	First Name	MI

Address (if different from Member address)	City	State	Zip

Ethnicity (Select One):
☐ Hispanic ☐ Non-Hispanic/Latino
☐ Refused ☐ Unknown

Race (Select at least one. If selecting more than one, circle one as primary):
☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Refused
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown

DEPENDENT C ☐ Change Enrollment ☐ Remove Dependent

☐ Enroll ☐ Remove
☐ Medical ☐ Vision ☐ Dental

Relationship to Member: ☐ Spouse ☐ Domestic Partner	Child of: ☐ Member/Spouse ☐ Domestic Partner	Overage Disabled Dependent of: ☐ Member/Spouse ☐ Domestic Partner

Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy)	Social Security, HICN, or Tax ID Number:	Medicare Eligible? ☐ Y ☐ N

Last Name	First Name	MI

Address (if different from Member address)	City	State	Zip

Ethnicity (Select One):
☐ Hispanic ☐ Non-Hispanic/Latino
☐ Refused ☐ Unknown

Race (Select at least one. If selecting more than one, circle one as primary):
☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Refused
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown

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DEPENDENT D ☐ Change Enrollment ☐ Remove Dependent			☐ Enroll ☐ Remove ☐ Medical ☐ Vision ☐ Dental
Relationship to Member: ☐ Spouse ☐ Domestic Partner	Child of: ☐ Member/Spouse ☐ Domestic Partner	Overage Disabled Dependent of: ☐ Member/Spouse ☐ Domestic Partner	
Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy)	Social Security, HICN, or Tax ID Number:	Medicare Eligible? ☐ Y ☐ N
Last Name	First Name	MI	
Address (if different from Member address)	City	State	Zip
Ethnicity (Select One): ☐ Hispanic ☐ Non-Hispanic/Latino ☐ Refused ☐ Unknown	**Race** (Select at least one. If selecting more than one, circle one as primary): ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Refused ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown		

DEPENDENT E ☐ Change Enrollment ☐ Remove Dependent			☐ Enroll ☐ Remove ☐ Medical ☐ Vision ☐ Dental
Relationship to Member: ☐ Spouse ☐ Domestic Partner	Child of: ☐ Member/Spouse ☐ Domestic Partner	Overage Disabled Dependent of: ☐ Member/Spouse ☐ Domestic Partner	
Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy)	Social Security, HICN, or Tax ID Number:	Medicare Eligible? ☐ Y ☐ N
Last Name	First Name	MI	
Address (if different from Member address)	City	State	Zip
Ethnicity (Select One): ☐ Hispanic ☐ Non-Hispanic/Latino ☐ Refused ☐ Unknown	**Race** (Select at least one. If selecting more than one, circle one as primary): ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Refused ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown		

5. Medical/Vision and Dental Plan Selection

Please check the box(es) below indicating your Plan selections. If you waive Medical/Vision coverage or Dental coverage when initially eligible, then choose to enroll in one or both of these plans during a future Open Enrollment period, you and any dependents enrolled will be subject to a 12-month waiting period for Vision and Dental plans (meaning only preventive and routine services will be covered during the first 12 months of coverage.)

Medical/Vision Plan: (Vision Plan **Pearl** is bundled with all medical plans)

☐ **Waive Medical Coverage**

Moda PPO Connexus Network Plan

- ☐ **Plan Birch** : ($ 800 deductible)
- ☐ **Plan Cedar** : ($ 1,200 deductible)
- ☐ **Plan Dogwood** : ($ 1,600 deductible)

Moda Synergy Network Plan*

- ☐ **Plan Birch** : ($ 800 deductible)
- ☐ **Plan Cedar** : ($ 1,200 deductible)
- ☐ **Plan Dogwood** : ($ 1,600 deductible)

* If selecting a Moda Medical Synergy Plan, prior to the coverage start date you must contact Moda Health to select a Medical Home Provider for each covered member. A list of Medical Home Providers can be found at: https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml

Dental Plans with Ortho:

☐ **Moda ODS Dental Plan 4** ☐ **Willamette Group Dental Plan 8** ☐ **Waive Dental Coverage**

6. Optional Life Insurance (Member paid, post-tax voluntary payroll deduction plans.)

Optional Life Insurance

As a newly eligible member for your first time enrollment the Optional Member Life has a guarantee issue enrollment amount of up to $100,000 and Optional Spouse/Domestic Partner Life has a guarantee issue enrollment amount of up to $30,000 without needing to submit a medical history to The Standard Insurance Company underwriting for approval. You must carry Member Optional Life Insurance in an equal or greater amount than any dependents you choose to cover.

You can find a link to the Medical History Statement on the OEBB website at:
http://www.oregon.gov/oha/OEBB/Pages/Forms.aspx

* Guarantee Issue, medical history is not required.
** You are required to submit a medical history statement on any coverage amount that is not guarantee Issue.

Member Optional Life Insurance ☐ Decline Coverage

New Hire/Newly Eligible Enrollment* (Employee Guaranteed Issue $100,000)	$ _____	($10,000 increments up to $100,000)
Additional Requested Amount Above Guarantee Issue** (Spouse Guaranteed Issue $30,000)	$ _____	($10,000 increments up to $400,000)
Total Requested Amount	$ _____	($500,000 maximum)

Spouse/Domestic Partner Optional Life Insurance ☐ Decline Coverage

New Hire/Newly Eligible Enrollment*	$ _____	($10,000 increments up to $30,000)
Additional Requested Amount Above Guarantee Issue**	$ _____	($10,000 increments up to $400,000)
Total Requested Amount	$ _____	($500,000 maximum)

Total requested amount must be equal to or less than member optional life insurance coverage.

Child(ren) Optional Life Insurance ☐ Decline Coverage

Total Requested Amount $ _____ ($2,000 increments up to $10,000 maximum)

Medical history is not required, you must enroll in member optional life to enroll your child(ren) in this coverage.

7. Beneficiary Designation

I elect:
☐ The Standard Order of Survivorship (If you have a Domestic Partner, an Affidavit* must be on file for distribution.)
☐ To designate the following as beneficiary (Attach additional sheets if necessary.)

Total of primary percentages must = 100% **Total of contingent percentages must = 100%**

Name	Address				
City	State	Zip	Relationship	Primary or Contingent ☐ OR ☐	Whole %
Name	Address				
City	State	Zip	Relationship	Primary or Contingent ☐ OR ☐	Whole %
Name	Address				
City	State	Zip	Relationship	Primary or Contingent ☐ OR ☐	Whole %

*Affidavit Information: OEBB's Affidavit of Domestic Partnership can be found online at:
http://www.oregon.gov/oha/OEBB/pages/Forms.aspx

8. Member Signature and Authorization

I declare the dependents listed above and I are eligible for the coverages requested per OEBB Administrative Rule (OAR)-Division. I have read and understand OAR-Division 10 concerning Definitions and can find this OAR at:

http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_010.html

I have read and understand OAR-Division 80, Sections 111-080-0040, 111-080-0045 and 111-080-0050 concerning Eligibility and Policy Term Violations and can find this OAR at:

http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_080.html

I understand I have 31 days to notify OEBB's HB2557 Coordinator of a Qualified Status Change (QSC) which affects eligibility. I have read and understand OAR-Division 40 concerning Enrollment and can find this OAR at:

http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_040.html

I understand the benefit elections I make are in effect for as long as I continue to meet OEBB's eligibility requirements, or until I elect to change them subject to the provisions of OEBB's plan. I understand I cannot alter my plan selections during the plan year unless I experience a QSC; then I am subject to the restrictions of the OEBB QSCs. I have reviewed and understand the Qualified Status Change (QSC) Matrix which can be found at:

http://www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx

I have read the benefit materials and I understand the limitations and qualifications of the OEBB benefits program. This is a self-pay program, I agree for monthly payments to be deducted from my financial institution by the date specified on the back of the ACH form, or my coverage will terminate. I will not be able to reinstate coverage until the next open enrollment period (if I requalify) or I may lose OEBB eligibility altogether.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

This election supersedes all elections and submissions I previously made for OEBB 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 perjury.

Member Signature _____ Date _____

Submit this completed form to 4J Benefits within the HR Department.

Do not submit this form to OEBB.

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