2018-19 Plan Year Licensed/MAPS Employee Midyear Change Form

Employer Use Only

Approved by _____

Date Approved _____

Effective Date _____

Use this form to update your benefits within 31 days of experiencing a Qualified Status Change (QSC) event.

These plan elections or changes will go into effect the first of the month after the event date unless you are requesting coverage that requires carrier approval. Carrier approval coverage will go into effect the first of the month following carrier approval. You may only make enrollment changes which are consistent with your QSC event. Some events may not allow the change you are requesting. Review the QSC Matrix for more information: http://www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx

1. Qualifying Status Change Event

Event Date: _____

A. Change in employment affecting plan availability or gain/loss of other coverage by
☐ Employee ☐ Spouse/Domestic Partner

B. Gain spouse/domestic partner through ☐ Marriage ☐ Domestic Partner meets eligibility

C. Loss of spouse/domestic partner by ☐ Divorce/Annulment ☐ Termination of Domestic Partnership ☐ Death

D. Gain dependent through
☐ Marriage/Domestic Partnership ☐ Birth/Adoption/Legal Custody ☐ Court Order ☐ Meeting Eligibility

E. Loss of dependent by ☐ Divorce/Termination of Domestic Partnership ☐ Ceasing to meet eligibility ☐ Death

F. Other events ☐ Moving out of current plan's service area ☐ Other

2. Employee Information

Last Name	First Name	MI
Social Security Number, or E Number	Gender ☐ Male ☐ Female	Date of Birth (mm-dd-yyyy)
Home Phone	Work Phone	Cell Phone
Personal Email	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

3. Dependent Information (Attach additional sheets if necessary)

You must report to your employer's benefits administrator 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)

* Domestic partner eligibility rules may vary by employer – verify with your benefits administrator before enrolling.
**Affidavit Information: If you are adding a domestic partner by OEBB Affidavit, you must submit the affidavit to your employer 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

DEPENDENT A ☐ Enroll ☐ Change ☐ Remove ☐ Medical ☐ Vision ☐ Dental

Relationship to Employee:	Child of:	Overage Disabled Dependent of:
☐ Spouse ☐ Domestic Partner	☐ Employee/Spouse ☐ Domestic Partner	☐ Employee/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 Employee 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 ☐ Enroll ☐ Change ☐ Remove ☐ Medical ☐ Vision ☐ Dental

Relationship to Employee:	Child of:	Overage Disabled Dependent of:
☐ Spouse ☐ Domestic Partner	☐ Employee/Spouse ☐ Domestic Partner	☐ Employee/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 Employee 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 ☐ Enroll ☐ Change ☐ Remove ☐ Medical ☐ Vision ☐ Dental

Relationship to Employee:	Child of:	Overage Disabled Dependent of:
☐ Spouse ☐ Domestic Partner	☐ Employee/Spouse ☐ Domestic Partner	☐ Employee/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 Employee 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 ☐ Enroll ☐ Change ☐ Remove			☐ Medical ☐ Vision ☐ Dental
Relationship to Employee: ☐ Spouse ☐ Domestic Partner	Child of: ☐ Employee/Spouse ☐ Domestic Partner		Overage Disabled Dependent of: ☐ Employee/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 Employee address)	City	State	Zip

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

4. Healthcare Plan Selections

MEDICAL

Medical Plan Selection:

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

☐ Moda Connexus PPO Birch ☐ Moda Synergy CCM Birch	☐ Moda Connexus PPO – Cedar ☐ Moda Synergy CCM - Cedar	☐ Moda Connexus PPO - Dogwood ☐ Moda Synergy CCM – Dogwood
☐ WAIVE Select this option if you do NOT want to participate in 4J health insurance coverage for 2018-19.		

VISION

Vision Plan Selection: VSP Choice Plus

Mandatory enrollment with a medical plan. Cannot elect vision without enrolling in medical.

DENTAL

Dental Plan Selection:

☐ Delta Dental Plan 5
☐ Willamette Dental
☐ Delta Dental Plan 6 – No orthodontia
☐ WAIVE Dental Coverage

DENTAL LATE ENROLLMENT PENALTY

I understand **if I decline dental coverage** when initially eligible or allow coverage to lapse, then choose to enroll at a future Open Enrollment period, any enrolled dependents and I will be subject to a 12-month waiting period, meaning only diagnostic and preventive care (cleanings, x-rays, and exams) will be covered for the first 12 months of dental coverage.

Employee Signature _____ Date _____

Eugene School District 4J
Attn: Human Resources Department
200 North Monroe St.
Eugene, OR 97402

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

In this section, OEBB is collecting tobacco usage information for you and your spouse/domestic partner (if applicable). This information will be used to determine your premium amount(s) for Optional Employee and Optional Spouse/Domestic Partner Life plans through The Standard. **You must complete this section even if you do not enroll in these plans.**

EMPLOYEE **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

6. Optional Life Insurance (Employee paid voluntary payroll deduction plans.)

As a newly eligible employee for your first time enrollment, the Optional Employee 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 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. If initial request is made with a QSC, guarantee issue amount is applicable.
** You are required to submit a medical history statement on any coverage amount that is not guarantee issue.

Employee Optional Life Insurance ☐ Enroll ☐ Change Enrollment ☐ Decline Coverage

Total Requested Amount $ _____ ($500,000 maximum)

Spouse/Domestic Partner Optional Life Insurance ☐ Enroll ☐ Change Enrollment ☐ Decline Coverage

Total Requested Amount $ _____ ($500,000 maximum)

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

Child(ren) Optional Life Insurance ☐ Enroll ☐ Change Enrollment ☐ Decline Coverage

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

Medical history is not required, you must enroll in employee 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			Phone	
City	State	Zip	Relationship	Primary or Contingent ☐ OR ☐	Whole %
Name	Address			Phone	
City	State	Zip	Relationship	Primary or Contingent ☐ OR ☐	Whole %

To change, remove or add beneficiaries, log into your MyOEBB account at MyOEBB.org

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

8. Employee Signature and Authorization

I declare the dependents listed above and I are eligible for the coverages requested per OEBB Administrative Rule (OAR)-Division 10. 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 my employer 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 have a QSC; then I am subject to the restrictions of the OEBB QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix 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. If necessary, I authorize premium payments deducted from my pay, unless I self-pay premiums. If I self-pay the premiums, I agree to submit monthly payments by the date specified, or my coverage will terminate; I will not be able to reinstate coverage until the next open enrollment period or 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.

Employee Signature _____ Date _____

Submit the completed form to your employer.

Do not submit this form to OEBB.

Eugene School District 4J
Attn: Human Resources Department
200 North Monroe St.
Eugene, OR 97402