

2021-22 Plan Year **Licensed Employee New Hire Enrollment Form**

| Employe | er Use Only |
|----------------|-------------|
| Approved by | |
| Date Approved | |
| Effective Date | |

Use this form to enroll in benefits when first eligible. Submit to your employer.

| 1. | Em | ployee | Inform | ation |
|----|----|--------|--------|-------|
|----|----|--------|--------|-------|

| 1. Employee Information | | | | | | | |
|--|------------------------------|------------------------|-------------------------------------|--|--|---------------------------------------|---------------|
| Last Name | | First Nar | ne | | | | MI |
| Employee ID, Social Security Number, or E Number | ber | | Gender | Male \square | Female | Date of Birth (mm | -dd-yyyy) |
| Home Phone | Work Phone | | | | Cell Phone | 1 | |
| May OEBB send text messages to this | number? St | tandard te | ext mess | age and da | tarates appl | l y. □ Yes □ |] No |
| Personal Email | | , | Work Emai | I | | | |
| Address | | | | 1 | | Apt or Space # | |
| City | | Sta | ite | Zip | County | | |
| Medicare Eligible? \square Yes \square No | Are yo | u serving | or did yo | ou ever ser | ve in the mil | itary? 🗌 Yes | □ No |
| If "Yes," do you authorize OEBB to send Veterans' Affairs (ODVA) for the purpose | - | | | • | epartment o | of □ Ye | s 🗆 No |
| Ethnicity (Select One): | | Non-Hispa | | | ☐ Refus | ed 🗆 U | Inknown |
| 2. Tobacco Usage (Responses in In this section, OEBB is collecting tobacco of information will be used to determine your p plans through The Standard. You must con | usage informa oremium amo | ation for yount(s) for | - ou and yo Optional B | ur spouse/d Employee a | nd Optional S | Spouse/Domestic | |
| EMPLOYEE In the last 12 months (Select o | ne): | | | | OMESTIC 2 months (| PARTNER Select one): | |
| ☐ I have used tobacco products ☐ I have <i>not</i> used tobacco products ☐ I have never used tobacco products | · . | ☐ My ☐ My | not curre spouse/de spouse/de | ently have a comestic par comestic par | spouse/dom tner has used tner has <i>not</i> | · · · · · · · · · · · · · · · · · · · | ducts |
| 3. Dependent Information (Attach a | additional sh | neets if ne | ecessary |) | | | |
| You must report to your employer's benefits or dependent child becomes ineligible for be misrepresentation of a material fact, for whi after eligibility was lost. | enefits. If you | do not re | port this c | hange on ti | me, OEBB m | ay consider that | an intentiona |
| If listing a Domestic Partner as a depend | • | e the type | _ | | - | | |
| By OEBB Affidavit of Domestic Partners | • | | • | • | , , | oy not required) | |
| * Domestic partner eligibility rules may vary | | • | • | | | • | malayes. |
| **Affidavit Information: If you are adding a c within five business days of this enrollment Partnership can be found online at: http://w | or the individ | lual's cove | rage will i | not be effec | tive. OEBB's | | |

| DEPENDENT A | | Enroll: | ☐ Medical ☐ Vision | | Dental |
|---|--|---|---|---|--|
| Relationship to Employee: | Child of: | | Overage Disabled Depender | nt of: | |
| ☐ Spouse ☐ Domestic Partner | ☐ Employee/Spous | se Domestic Partner | ☐ Employee/Spouse ☐ | Dome | stic Partner |
| Gender Date of Birth (mm-dd-yy | yy) Social Security, F | IICN, or Tax ID Number: | | Medic | are Eligible? |
| □М□Г | | | | | $Y \square N$ |
| Last Name | | First Name | | | MI |
| Address (if different from employee addre | ss) | C | City | State | Zip |
| Ethnicity (Select One): | Race (Select at le | east one. If selecting more | than one, circle one as prir | mary): | • |
| ☐ Hispanic ☐ Non-Hispanic/Latin | o 🛘 🗆 Asian 🗀 Am | erican Indian/Alaska Nativ | e 🗌 Black/African Americ | an 🗌 | Refused |
| ☐ Refused ☐ Unknown | ☐ Native Hawaii | an/Other Pacific Islander | \square White \square Other \square Un | known | |
| DEPENDENT B | | Enroll: | ☐ Medical ☐ Vision | | Dental |
| Relationship to Employee: | Child of: | | Overage Disabled Depender | nt of: | |
| ☐ Spouse ☐ Domestic Partner | ☐ Employee/Spous | se Domestic Partner | ☐ Employee/Spouse ☐ | Dome | stic Partner |
| Gender Date of Birth (mm-dd-yy | yy) Social Security, H | IICN, or Tax ID Number: | | 1 | are Eligible? Y □ N |
| Last Name | | First Name | | | MI |
| Address (if different from Employee addre | ss) | C | City | State | Zip |
| Ethnicity (Select One): | Race (Select at le | east one. If selecting more | than one, circle one as prir | mary): | · |
| ☐ Hispanic ☐ Non-Hispanic/Latin | o ☐ Asian ☐ Am | erican Indian/Alaska Nativ | e 🗌 Black/African Americ | an 🗌 | Refused |
| ☐ Refused ☐ Unknown | ☐ Native Hawaii | an/Other Pacific Islander | \square White \square Other \square Un | known | |
| | | | | | |
| DEPENDENT C | | Enroll: | ☐ Medical ☐ Vision | | Dental |
| Relationship to Employee: | Child of: | | Overage Disabled Depender | nt of: | |
| | | Enroll: se ☐ Domestic Partner | | nt of: Dome | stic Partner |
| Relationship to Employee: | ☐ Employee/Spous | | Overage Disabled Depender | nt of: Dome | |
| Relationship to Employee: Spouse Domestic Partner Gender Date of Birth (mm-dd-yy | ☐ Employee/Spous | se Domestic Partner | Overage Disabled Depender | nt of: Dome | stic Partner |
| Relationship to Employee: Spouse Domestic Partner Gender Date of Birth (mm-dd-yy | ☐ Employee/Spous yy) Social Security, H | se Domestic Partner IICN, or Tax ID Number: First Name | Overage Disabled Depender | nt of: Dome | stic Partner are Eligible? Y □ N |
| Relationship to Employee: Spouse Domestic Partner Gender Date of Birth (mm-dd-yy M F Last Name | ☐ Employee/Spous yy) Social Security, H | se Domestic Partner IICN, or Tax ID Number: First Name | Overage Disabled Depender Employee/Spouse | Dome Medica | stic Partner are Eligible? Y □ N |
| Relationship to Employee: Spouse Domestic Partner Gender Date of Birth (mm-dd-yy M F Last Name Address (if different from Employee address) | Employee/Spous | se Domestic Partner HICN, or Tax ID Number: First Name cast one. If selecting more | Overage Disabled Depender Employee/Spouse | Dome Medic | stic Partner are Eligible? Y □ N MI |
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| Relationship to Employee: Spouse Domestic Partner Gender Date of Birth (mm-dd-yy Last Name Address (if different from Employee addres Ethnicity (Select One): Hispanic Non-Hispanic/Lating | Employee/Spous yy) Social Security, H sss) Race (Select at le | Domestic Partner HICN, or Tax ID Number: First Name cast one. If selecting more erican Indian/Alaska Nativ | Overage Disabled Depender Employee/Spouse City than one, circle one as prire Black/African America | State mary): aknown | stic Partner are Eligible? Y □ N MI |
| Relationship to Employee: Spouse Domestic Partner Gender Date of Birth (mm-dd-yy Last Name Address (if different from Employee addres Ethnicity (Select One): Hispanic Non-Hispanic/Lating Refused Unknown | Employee/Spous yy) Social Security, H sss) Race (Select at le | Se Domestic Partner HICN, or Tax ID Number: First Name cast one. If selecting more erican Indian/Alaska Nativ an/Other Pacific Islander | Overage Disabled Depender Employee/Spouse City than one, circle one as prine Black/African Americ White Other Un | nt of: Dome Medica State mary): can can can can can can can can | stic Partner are Eligible? Y □ N MI Zip Refused |
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4. Healthcare Plan Selections

| the "non-coordinated" benefit if using a provider in the Connexus network. Any services by a provider outside the Connexus network be paid at the "out-of-network" level regardless of wheter or not the individual has chosen a PCP 360 with Moda. A list of PCP 360 providers can be found at: https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml Kaiser Plan 2 | profinated* benefit if using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive inconcoordinated benefit if using a provider in the Connexus network. Any services by a provider outside the Connexus network will had at the "out-of-network" level regardless of wheter or not the individual has chosen a PCP 360 with Moda. A list of PCP 360 viders can be found at: https://www.moda/heatth.com/Provider/Search/faces/webpages/home.xhtml Kaiser Plan 2 | | N | MEDICAL | | | | |
|--|---|---|---|---|--|--|--|--|
| WAIVE Select this option if you do NOT want to participate in 4J health insurance coverage for 2021-22. VISION Vision Plan Selection: VSP Choice Plus Mandatory enrollment with a medical plan. Cannot elect vision without enrolling in medical. Dental Plan Selection: Delta Dental Plan 6 – No orthodontia WAIVE Dental Coverage | VISION Sion Plan Selection: VSP Choice Plus Mandatory enrollment with a medical plan. Cannot elect vision without enrolling in medical. DENTAL DENTAL Delta Dental Plan 5 Williamette Dental DENTAL LATE ENROLLMENT PENALTY Understand if I decline dental coverage when initially eligible or allow coverage to lapse, then choose to enroll at future Open Enrollment period, any enrolled dependents and I will be subject to a 12-month waiting period, eaning only diagnostic and preventive care (cleanings, x-rays, and exams) will be covered for the first 12 months idental coverage. Employee Signature Determinant improve paid voluntary payroll deduction plans.) a newly eligible employee for your first time enrollment, the Optional Employee Life has a guarantee issue* enrollment amount of up to \$200,000 and Optional Spouse/Domestic Partner Life has a guarantee issue* enrollment amount of up to \$200,000 and Optional Spouse/Domestic Partner Life has a guarantee indicated 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/ola/OEBB/Pages/Forms.aspx Jarantee 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. | "coordinated" benefit if using a provider in the "non-coordinated" benefit if using a pro- be paid at the "out-of-network" level regard | the Connexus netwo ovider in the Connexu lless of wheter or not | rk. If an individua is network. Any s the individual ha | al has not chosen a PCP 360 services by a provider outside as chosen a PCP 360 with Mo | with Moda, they will receive the Connexus network will | | |
| 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 Delta Dental Plan 6 – No orthodontia Walve Dental Coverage DENTAL LATE ENROLLMENT PENALTY I understand if I decline dental coverage when initially eligible or allow coverage to lapse, then choose to en 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 mo of dental coverage. Employee Signature Date | VISION Sion Plan Selection: VSP Choice Plus | ☐ Kaiser Plan 2 | ☐ Moda Plan | 2 | ☐ Moda Plan 3 | ☐ Moda Plan 4 | | |
| Vision Plan Selection: DENTAL | VSP Choice Plus Mandatory enrollment with a medical plan. Cannot elect vision without enrolling in medical. | ☐ WAIVE Select this option if you | ou do NOT want to | participate in | 4J health insurance cove | rage for 2021-22. | | |
| DENTAL Dental Plan Selection: Delta Dental Plan 5 Dental Poental Plan 5 Dental Coverage DENTAL LATE ENROLLMENT PENALTY I understand if I decline dental coverage when initially eligible or allow coverage to lapse, then choose to en 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 moof dental coverage. Employee Signature Date | DENTAL | | | VISION | | | | |
| Dental Plan Selection: Delta Dental Plan 5 Delta Dental Plan 6 – No orthodontia Willamette Dental DENTAL LATE ENROLLMENT PENALTY I understand if I decline dental coverage when initially eligible or allow coverage to lapse, then choose to en 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 moof dental coverage. Employee Signature Date | ental Plan Selection: Delta Dental Plan 5 | | | edical plan. Canno | ot elect vision without enrolling in | n medical. | | |
| □ Delta Dental Plan 5 □ Willamette Dental □ 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 en 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 moof dental coverage. Employee Signature Date | Delta Dental Plan 5 | | | DENTAL | | | | |
| I understand if I decline dental coverage when initially eligible or allow coverage to lapse, then choose to en 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 moof dental coverage. Employee Signature Date | understand if I decline dental coverage when initially eligible or allow coverage to lapse, then choose to enroll at future Open Enrollment period, any enrolled dependents and I will be subject to a 12-month waiting period, the earning only diagnostic and preventive care (cleanings, x-rays, and exams) will be covered for the first 12 months is dental coverage. Employee Signature Date Optional Life Insurance (Employee paid voluntary payroll deduction plans.) a newly eligible employee for your first time enrollment, the Optional Employee Life has a guarantee issue* enrollment count of up to \$200,000 and Optional Spouse/Domestic Partner Life has a guarantee issue* enrollment amount of up to 0,000 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 Jarantee 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. | ☐ Delta Dental Plan 5 | | | | | | |
| 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 moof dental coverage. Employee Signature Date | future Open Enrollment period, any enrolled dependents and I will be subject to a 12-month waiting period, deaning only diagnostic and preventive care (cleanings, x-rays, and exams) will be covered for the first 12 months idental coverage. Employee Signature Date Optional Life Insurance (Employee paid voluntary payroll deduction plans.) a newly eligible employee for your first time enrollment, the Optional Employee Life has a guarantee issue* enrollment ount of up to \$200,000 and Optional Spouse/Domestic Partner Life has a guarantee issue* enrollment amount of up to 0,000 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 Date Date | · | | | | | | |
| | Optional Life Insurance (Employee paid voluntary payroll deduction plans.) a newly eligible employee for your first time enrollment, the Optional Employee Life has a guarantee issue* enrollment ount of up to \$200,000 and Optional Spouse/Domestic Partner Life has a guarantee issue* enrollment amount of up to 0,000 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 Juarantee 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. | a future Open Enrollment period, a meaning only diagnostic and preven | ny enrolled deper | ndents and I w | rill be subject to a 12-mon | th waiting period, | | |
| 6. Optional Life Insurance (Employee paid voluntary payroll deduction plans.) | a newly eligible employee for your first time enrollment, the Optional Employee Life has a guarantee issue* enrollment ount of up to \$200,000 and Optional Spouse/Domestic Partner Life has a guarantee issue* enrollment amount of up to 0,000 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 uarantee 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 Signature | | | Date | | | |
| | ount of up to \$200,000 and Optional Spouse/Domestic Partner Life has a guarantee issue* enrollment amount of up to 0,000 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 Juarantee 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. | 6. Optional Life Insurance (Employee paid voluntary payroll deduction plans.) | | | | | | |
| \$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. | , , , , , , | | | | | | | |
| | pployee Optional Life Insurance □ Enroll □ Change Enrollment □ Decline Coverage | <u></u> | | | | | | |
| | | Total F | equested Amount | \$ | (\$500,0 | 00 maximum) | | |
| Total Requested Amount \$ (\$500,000 maximum) | Total Requested Amount \$ (\$500,000 maximum) | Spouse/Domestic Partner Option | al Life Insurance | ☐ Enroll | ☐ Change Enrollment | ☐ Decline Coverage | | |
| | | Total F | Requested Amount | \$ | (\$500,0 | - 00 maximum) | | |
| Spouse/Domestic Partner Optional Life Insurance | ouse/Domestic Partner Optional Life Insurance | Total requested amo | ount must be equal to | or less than emplo | oyee optional life insurance cove | erage. | | |
| Spouse/Domestic Partner Optional Life Insurance | ouse/Domestic Partner Optional Life Insurance | Child(ren) Optional Life Insurance | • | ☐ Enroll | ☐ Change Enrollment | ☐ Decline Coverage | | |
| Spouse/Domestic Partner Optional Life Insurance | Total requested amount must be equal to or less than employee optional life insurance coverage. | Total Requested Am | ount \$ | | (\$2,000 increments up | o to \$10,000 maximum) | | |
| Tatal Danuaria d'Amarina de | Total Democrated Assessment C | I otal F | equestea Amount | Ф | (\$500,0 - | υυ maximum) | | |
| Total Requested Amount \$ (\$500,000 maximum) | Total Requested Amount \$ (\$500,000 maximum) | Spouse/Domestic Partner Option | al Life Insurance | ☐ Enroll | ☐ Change Enrollment | ☐ Decline Coverage | | |
| | | | | | | <u>-</u> | | |
| Spouse/Domestic Partner Optional Life Insurance | ouse/Domestic Partner Optional Life Insurance | | • | | _ | • | | |
| Spouse/Domestic Partner Optional Life Insurance | ouse/Domestic Partner Optional Life Insurance | | | | <u> </u> | <u></u> | | |
| Spouse/Domestic Partner Optional Life Insurance | Total requested amount must be equal to or less than employee optional life insurance coverage. | | _ | - | - | _ | | |
| Spouse/Domestic Partner Optional Life Insurance | Total Requested Amount Total requested amount must be equal to or less than employee optional life insurance coverage. Change Enrollment Decline Coverage | • | | | رپکی,000 increments u - ا life to enroll your child(ren) in t | , | | |

500 Summer Street NE, E-88, Salem, OR 97301-1063 Phone: 888-469-6322 Fax: 503-378-5832

7. Beneficiary Designation ☐ 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 Relationship City State Zip Primary or Contingent Whole % OR \square Name Address Phone City State Zip Relationship Primary or Contingent Whole % OR \square 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.

Submit the completed form to your employer.

Do not submit this form to OEBB.

500 Summer Street NE, E-88, Salem, OR 97301-1063 Phone: 888-469-6322 Fax: 503-378-5832

Employee Signature