



2021-22 Plan Year 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 <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Domestic Partner
B. Gain spouse/domestic partner through <input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Partner meets eligibility
C. Loss of spouse/domestic partner by <input type="checkbox"/> Divorce/Annulment <input type="checkbox"/> Termination of Domestic Partnership <input type="checkbox"/> Death
D. Gain dependent through <input type="checkbox"/> Marriage/Domestic Partnership <input type="checkbox"/> Birth/Adoption/Legal Custody <input type="checkbox"/> Court Order <input type="checkbox"/> Meeting Eligibility
E. Loss of dependent by <input type="checkbox"/> Divorce/Termination of Domestic Partnership <input type="checkbox"/> Ceasing to meet eligibility <input type="checkbox"/> Death
F. Other events <input type="checkbox"/> Moving out of current plan's service area <input type="checkbox"/> Other

2. Employee Information

Last Name		First Name			MI
Social Security Number, or E Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you serving or did you ever serve in the military? <input type="checkbox"/> Yes <input type="checkbox"/> 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?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Ethnicity (Select One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown					
Race (Select at least one. If selecting more than one, circle one as primary): <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Refused <input type="checkbox"/> 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				<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Remove		<input type="checkbox"/> Medical		<input type="checkbox"/> Vision		<input type="checkbox"/> Dental	
Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			Child of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			Overage Disabled Dependent of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner					
Gender <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (mm-dd-yyyy)		Social Security, HICN, or Tax ID Number:				Medicare Eligible? <input type="checkbox"/> Y <input type="checkbox"/> N			
Last Name				First Name				MI			
Address (if different from Employee address)						City		State		Zip	
Ethnicity (Select One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown				Race (Select at least one. If selecting more than one, circle one as primary): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown							
DEPENDENT B				<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Remove		<input type="checkbox"/> Medical		<input type="checkbox"/> Vision		<input type="checkbox"/> Dental	
Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			Child of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			Overage Disabled Dependent of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner					
Gender <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (mm-dd-yyyy)		Social Security, HICN, or Tax ID Number:				Medicare Eligible? <input type="checkbox"/> Y <input type="checkbox"/> N			
Last Name				First Name				MI			
Address (if different from Employee address)						City		State		Zip	
Ethnicity (Select One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown				Race (Select at least one. If selecting more than one, circle one as primary): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown							
DEPENDENT C				<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Remove		<input type="checkbox"/> Medical		<input type="checkbox"/> Vision		<input type="checkbox"/> Dental	
Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			Child of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			Overage Disabled Dependent of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner					
Gender <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (mm-dd-yyyy)		Social Security, HICN, or Tax ID Number:				Medicare Eligible? <input type="checkbox"/> Y <input type="checkbox"/> N			
Last Name				First Name				MI			
Address (if different from Employee address)						City		State		Zip	
Ethnicity (Select One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown				Race (Select at least one. If selecting more than one, circle one as primary): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown							



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

4. Healthcare Plan Selections

MEDICAL

Medical Plan Selection: If enrolled in a Moda plan, each covered individual must choose a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit if using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive the "non-coordinated" benefit if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level regardless of whether 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>

<input type="checkbox"/> Kaiser HMO Plan 2	<input type="checkbox"/> Moda Plan 3	<input type="checkbox"/> Moda Plan 4
<input type="checkbox"/> 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

Dental Plan Selection:

- | | |
|--|---|
| <input type="checkbox"/> Delta Dental Plan 5 | <input type="checkbox"/> Delta Dental Plan 6 – No orthodontia |
| <input type="checkbox"/> Willamette Dental | <input type="checkbox"/> 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



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

In this section, OEGB 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):
<input type="checkbox"/> I have used tobacco products <input type="checkbox"/> I have not used tobacco products <input type="checkbox"/> I have never used tobacco products	<input type="checkbox"/> I do not currently have a spouse/domestic partner <input type="checkbox"/> My spouse/domestic partner has used tobacco products <input type="checkbox"/> My spouse/domestic partner has not used tobacco products <input type="checkbox"/> 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 \$200,000 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 OEGB website at:

<http://www.oregon.gov/oha/OEGB/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	<input type="checkbox"/> Enroll	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> Decline Coverage
Total Requested Amount	\$ _____		(\$500,000 maximum)

Spouse/Domestic Partner Optional Life Insurance	<input type="checkbox"/> Enroll	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> 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	<input type="checkbox"/> Enroll	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> 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 <input type="checkbox"/> OR <input type="checkbox"/>	Whole %
Name	Address			Phone	
City	State	Zip	Relationship	Primary or Contingent <input type="checkbox"/> OR <input type="checkbox"/>	Whole %

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

*Affidavit Information: OEGB's Affidavit of Domestic Partnership can be found online at:

<http://www.oregon.gov/oha/OEGB/pages/Forms.aspx>



8. Employee Signature and Authorization

I declare the dependents listed above and I am eligible for the coverages requested per OEGB 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 OEGB's eligibility requirements, or until I elect to change them subject to the provisions of OEGB'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 OEGB QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix at <http://www.oregon.gov/oha/OEGB/Pages/QSC-Matrix.aspx>

I have read the benefit materials and I understand the limitations and qualifications of the OEGB 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 OEGB 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 OEGB 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 OEGB.