2022-23 Plan Year
Licensed Guest Teacher Benefit Enrollment Form

Upon completion, please return this form to Eugene School District 4J, Human Resources

Employee Information

Last Name	First Name	MI
Employee ID, 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

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 member's 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

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DEPENDENT A

Enroll: ☐ Medical ☐ Vision ☐ Dental

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

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

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

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

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

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

Enroll: ☐ Medical ☐ Vision ☐ Dental

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

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

Medical

Medical plan selection: _____

Write in plan selection.

If enrolled in a Moda medical 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

If you are choosing to *not* enroll in an OEBB medical plan, select the WAIVE option:

☐ **WAIVE** Select this option if you will ***not*** receive a financial incentive from your employer regardless of whether or not you have other medical coverage.

Note: Many employers do not offer a financial incentive, in those cases you should select "Waive."

If you choose to waive medical coverage, you are not able to elect vision or dental coverage.

VISION

Vision Plan Selection: **VSP Choice Plus** ☐ *Decline Vision

*You are automatically enrolled in VSP Choice Plus vision insurance if you elect a medical plan. The cost of vision insurance is bundled into your medical premium. See rate sheet for monthly premiums: http://www.4j.lane.edu/hr/benefits/licensed-substitutes/

DENTAL

Dental Plan Selection: _____ ☐ Decline Dental

Write in plan selection.

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 dependents enrolled 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

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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.