



Open Enrollment Form

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

Use this form to enroll in or change plans during Open Enrollment. Plan elections or changes will go into effect October 1, unless you are requesting coverage that requires carrier approval. Carrier approval coverage will go into effect October 1st or the first of the month following carrier approval, whichever is later.

If you are newly benefits eligible and your benefits become effective prior to October 1, you should also complete a "New Hire Enrollment Form" to make benefit selections for the remainder of this Plan Year.

Employee information

Last name		First name		M.I.	
Employee ID, E number or Social Security number			Gender		Date of birth (<i>mm/dd/yyyy</i>)
			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other		
Home phone number		Work phone number		Cell phone number	
May OEBB send text messages to this number? Standard text message and data rates apply.					<input type="checkbox"/> Yes <input type="checkbox"/> No
Address		<input type="checkbox"/> Check if new address		Apartment or Space#	
City		State		ZIP	County
Personal email			Work email		
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	

Tobacco usage (*Responses in this section are required*)

Employee In the last 12 months (<i>select one</i>): <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	Spouse/Domestic partner In the last 12 months (<i>select one</i>): <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
---	--

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, OEGB may consider that an intentional misrepresentation of a material fact, for which OEGB 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 OEGB 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 OEGB 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. OEGB's Affidavit of Domestic Partnership can be found online at: <https://www.oregon.gov/oha/OEGB/Pages/Forms.aspx>

Dependent A	<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Remove dependent	<input type="checkbox"/> Enroll	<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	<input type="checkbox"/> Child	
Gender	Date of birth <i>(mm/dd/yyyy)</i>	Social Security, HICN, or Tax ID number:		Medicare eligible?
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other				<input type="checkbox"/> Y <input type="checkbox"/> N
Last name	First name	Middle		
Address <i>(if different from employee address)</i>		City	State	ZIP
Ethnicity <i>(Select one):</i>	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown
Race <i>(Select at least one. If selecting more than one, circle one as primary):</i>				
<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	

Dependent B	<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Remove dependent	<input type="checkbox"/> Enroll	<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	<input type="checkbox"/> Child	
Gender	Date of birth <i>(mm/dd/yyyy)</i>	Social Security, HICN, or Tax ID number:		Medicare eligible?
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other				<input type="checkbox"/> Y <input type="checkbox"/> N
Last name	First name	Middle		
Address <i>(if different from employee address)</i>		City	State	ZIP
Ethnicity <i>(Select one):</i>	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown
Race <i>(Select at least one. If selecting more than one, circle one as primary):</i>				
<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	

Dependent C	<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Remove dependent	<input type="checkbox"/> Enroll	<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	<input type="checkbox"/> Child				
Gender	Date of birth (mm/dd/yyyy)	Social Security, HICN, or Tax ID number:		Medicare eligible?			
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other				<input type="checkbox"/> Y <input type="checkbox"/> N			
Last name	First name		Middle				
Address (if different from employee address)		City	State	ZIP			
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				

Dependent D	<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Remove dependent	<input type="checkbox"/> Enroll	<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	<input type="checkbox"/> Child				
Gender	Date of birth (mm/dd/yyyy)	Social Security, HICN, or Tax ID number:		Medicare eligible?			
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other				<input type="checkbox"/> Y <input type="checkbox"/> N			
Last name	First name		Middle				
Address (if different from employee address)		City	State	ZIP			
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				

Double coverage surcharge info

Are any of your covered family members offered medical insurance as an employee through OEBC or PEBC? Yes No

Are they enrolled in OEBC or PEBC medical insurance offered? (If both answers are Yes, a \$5 monthly surcharge will be applied.) Yes No

Healthcare plan selections

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 OEGB medical plan, select one of the following options:

OPT-OUT

Select this option if you and all your eligible dependents have other employer-sponsored group coverage and you will receive a financial incentive from your employer to not enroll in OEGB medical coverage.

By selecting this option, I confirm all eligible dependents have other group coverage.

You and your eligible dependents **MUST** have other employer-sponsored group medical coverage to opt-out. Participation or enrollment in the Individual Marketplace Coverage, Oregon Health Plan, Medicaid, or Student Health Insurance does **NOT** qualify for OEGB opt-out.

You must provide proof of other group coverage to your employer within five business days or your opt-out will not be effective:

Carrier	Policy number	Group number
Primary policy holder	Employer	Effective date (mm/dd/yyyy)

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.”

Dental

Dental plan selection: _____

Decline Dental

Write in plan selection.

Vision

Vision plan selection: _____

Decline Vision

Write in plan selection (*Must be enrolled in Kaiser Medical to enroll in Kaiser Vision*).

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

Optional plans *(Employee paid voluntary payroll deduction plans)*

Plan offering and availability is determined by your employer. Contact your employer for coverage information and to find out which optional plans are available to you.

A. Optional life insurance

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 OEBC website at:

<https://www.oregon.gov/oha/OEBC/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

Decline coverage

New enrollment* \$ (\$10,000 increments up to \$200,000)

Additional requested amount above
guarantee issue** \$ (\$10,000 increments up to \$300,000)

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 \$470,000)

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

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.

B. Optional Accidental Death & Dismemberment (AD&D) insurance

Employee optional AD&D

Decline coverage

Total requested amount \$ (\$10,000 increments up to \$500,000 maximum)

Medical history is not required.

Spouse/domestic partner optional AD&D

Decline coverage

Total requested amount \$ (\$10,000 increments up to \$500,000 maximum)

Medical history is not required. Total requested amount must be equal or less than employee optional AD&D coverage.

Child(ren) Optional AD&D

Decline coverage

Total requested amount \$ (\$2,000 increments up to \$10,000 maximum)

Medical history is not required. You must enroll in employee optional AD&D to enroll your child(ren) in this coverage.

C. Voluntary disability insurance

Monthly premium is calculated on a percentage of your basic monthly salary. *A late enrollment penalty will apply if you choose to enroll in coverage after your initial eligibility period, or allow coverage to lapse.*

Voluntary short term disability Enroll for coverage Decline coverage

Short term disability plans pay weekly benefits with coverage dates ending after 60 or 90 days depending upon plan enrollment.

Voluntary long term disability Enroll for coverage Decline coverage

Long term disability plans pay monthly benefits with benefits starting after 60 or 90 day waiting periods depending upon plan enrollment.

D. Voluntary long term care insurance

Employee Long Term Care enrollment as a newly eligible employee has guarantee issue* amounts of up to \$6,000 in monthly benefit, professional home care option for 3 or 6 year duration without having to submit medical history for enrollment approval. Enrollment requests for unlimited duration, amount over \$6,000, total home care, and 5% simple inflation options, enrollment after first eligible or a future date, and Spouse/Domestic Partner Long Term Care will require the UNUM medical history statement to be filled out and submitted to UNUM.

You can find a link to UNUM forms on the OEBC website:

<https://www.oregon.gov/oha/OEBC/Pages/Forms.aspx>

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

Employee long term care*

Decline Coverage

Plan option	Coverage amount	Duration
<input type="checkbox"/> Professional Home Care	<input type="checkbox"/> \$2,000	<input type="checkbox"/> 3 Years
<input type="checkbox"/> Total Home Care	<input type="checkbox"/> \$3,000	<input type="checkbox"/> 6 Years
<input type="checkbox"/> Professional Home Care – 5% inflation	<input type="checkbox"/> \$4,000	<input type="checkbox"/> Unlimited
<input type="checkbox"/> Total Home Care – 5% inflation	<input type="checkbox"/> \$5,000	
	<input type="checkbox"/> \$6,000	
	<input type="checkbox"/> \$7,000	
	<input type="checkbox"/> \$8,000	
	<input type="checkbox"/> \$9,000	

Spouse/domestic partner long term care*

Decline Coverage

Plan option	Coverage amount	Duration
<input type="checkbox"/> Professional Home Care	<input type="checkbox"/> \$2,000	<input type="checkbox"/> 3 Years
<input type="checkbox"/> Total Home Care	<input type="checkbox"/> \$3,000	<input type="checkbox"/> 6 Years
<input type="checkbox"/> Professional Home Care – 5% Inflation	<input type="checkbox"/> \$4,000	<input type="checkbox"/> Unlimited
<input type="checkbox"/> Total Home Care – 5% inflation	<input type="checkbox"/> \$5,000	
	<input type="checkbox"/> \$6,000	
	<input type="checkbox"/> \$7,000	
	<input type="checkbox"/> \$8,000	
	<input type="checkbox"/> \$9,000	

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 <input type="checkbox"/> OR <input type="checkbox"/>	Whole %
Name			Address		
City	State	ZIP	Relationship	Primary or contingent <input type="checkbox"/> OR <input type="checkbox"/>	Whole %
Name			Address		
City	State	ZIP	Relationship	Primary or contingent <input type="checkbox"/> OR <input type="checkbox"/>	Whole %
Name			Address		
City	State	ZIP	Relationship	Primary or contingent <input type="checkbox"/> OR <input type="checkbox"/>	Whole %

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

<https://www.oregon.gov/oha/OEBC/Pages/Forms.aspx>

Employee signature and authorization

Review all OEGB Administrative Rules (OARs) at:

<https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=186>

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](#).

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.

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](#).

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 which can be found at:

<https://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.