



Enrollment

HB 2557 Member

OEBB Use Only

Approved by _____ Date _____

Effective Date _____

1. Member Information

E Number or Social Security Number (*not required*)

Last Name	First Name	MI	Date of Birth			
Contact Address	Apt #	City	State	Zip	County	
E-mail	Work Phone		Home Phone			

2. Dependent Information

Attach separate sheet if necessary.

Relationship Codes: SP=Spouse, CH=Employee and/or Spouse's child, DD=Disabled Dependent, DP=Domestic Partner, DPCH=Domestic Partner's Child

Last Name	First Name	M	Birth Date (mm/dd/yyyy)	Relationship Code	Gender		Enroll Medical Coverage
					M	F	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you listed a Domestic Partner above, indicate the type of Domestic Partnership

By OEBB Affidavit*

By Registered Certificate (no copy required)

***Affidavit Information**

If you are adding a domestic partner by affidavit, you must submit the affidavit to your educational entity within five business days of this enrollment, or the individual's coverage will be terminated back to the effective date.

3. Medical Plan Selection

ODS Medical Plan 8 with Pharmacy Plan C

ODS Medical Plan 9

4. Medicare Coverage (Attach separate sheet if necessary)

The following individuals are covered by Medicare:

<input type="checkbox"/> No one listed on this form is covered by Medicare.	<input type="checkbox"/> Me	<input type="checkbox"/> My Spouse or Domestic Partner Name: _____ SSN/HICN: _____	<input type="checkbox"/> A Dependent Child Name: _____ SSN/HICN: _____
---	-----------------------------	--	--

5. Member Signature and Authorization

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application 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 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.

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.

If you fail to report on time a change that makes an enrolled family member ineligible, OEGB may consider your omission an intentional misrepresentation of a fact material to your enrollment. In that case, OEGB may terminate the family member's coverage retroactively.

This form supersedes all forms 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 false claims.

Employee Signature

Date

Send your completed form to OEGB:	1225 Ferry St. SE Salem, OR 97301-4281	Ph: 1-888-469-6322, Fax: 503-378-5832
--	---	--