



# Enrollment Form

Use this form to enroll in benefits when first eligible.

**Educational Entity Use Only**

Rec'd by \_\_\_\_\_ Date \_\_\_\_\_

Effective Date \_\_\_\_\_

## 1. Employee Information

Educational Entity		Employee ID, SSN, or E Number		
Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		Medicare Eligible? <input type="checkbox"/> YES SSN/HICN <input type="checkbox"/> NO		
Race (select one or more, 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				
Contact Address	<input type="checkbox"/> Check if New Address	Apt #	City	State Zip
Work E-mail		Personal E-mail		
Work Phone		Home Phone		

## 2. Dependent Information

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 make this report on time, the change will be effective the first of the month after your report or the first day of the month after the QSC event occurred. 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 (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 not be effective.

**Domestic partner eligibility rules may vary by educational entity – verify with your employer's benefits administrator before enrolling.**

<b>Dependent A</b>		Relationship Codes ("Rel Code" below): SP=Spouse, CH=Employee and/or Spouse's child, DD=Disabled Dependent, DP=Domestic Partner, DP CH=Domestic Partner's Child						
Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Rel Code	Gender M F <input type="checkbox"/> <input type="checkbox"/>	Enroll Med Den Vis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Add Drop <input type="checkbox"/> <input type="checkbox"/>
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		Medicare Eligible? <input type="checkbox"/> YES SSN/HICN <input type="checkbox"/> NO						
Race (select one or more, 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								
Address (if different from employee address)		Apt #	City	State	Zip			

<b>Dependent B</b>		Relationship Codes ("Rel Code" below): SP=Spouse, CH=Employee and/or Spouse's child, DD=Disabled Dependent, DP=Domestic Partner, DP CH=Domestic Partner's Child						
Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Rel Code	Gender M F <input type="checkbox"/> <input type="checkbox"/>	Enroll Med Den Vis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Add Drop <input type="checkbox"/> <input type="checkbox"/>
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		Medicare Eligible? <input type="checkbox"/> YES SSN/HICN <input type="checkbox"/> NO						
Race (select one or more, 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								
Address (if different from employee address)		Apt #	City	State	Zip			

Additional dependents may be listed on the next page. Attach additional sheets if necessary.

<b>Dependent C</b>		<b>Relationship Codes</b> ("Rel Code" below): <b>SP</b> =Spouse, <b>CH</b> =Employee and/or Spouse's child, <b>DD</b> =Disabled Dependent, <b>DP</b> =Domestic Partner, <b>DP CH</b> =Domestic Partner's Child					
Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Rel Code	Gender M F <input type="checkbox"/> <input type="checkbox"/>	Enroll Med Den Vis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Add Drop <input type="checkbox"/> <input type="checkbox"/>
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		Medicare Eligible? <input type="checkbox"/> YES SSN/HICN _____ <input type="checkbox"/> NO					
Race (select one or more, 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					
Address (if different from employee address)		Apt #	City	State	Zip		

<b>Dependent D</b>		<b>Relationship Codes</b> ("Rel Code" below): <b>SP</b> =Spouse, <b>CH</b> =Employee and/or Spouse's child, <b>DD</b> =Disabled Dependent, <b>DP</b> =Domestic Partner, <b>DP CH</b> =Domestic Partner's Child					
Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Rel Code	Gender M F <input type="checkbox"/> <input type="checkbox"/>	Enroll Med Den Vis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Add Drop <input type="checkbox"/> <input type="checkbox"/>
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		Medicare Eligible? <input type="checkbox"/> YES SSN/HICN _____ <input type="checkbox"/> NO					
Race (select one or more, 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					
Address (if different from employee address)		Apt #	City	State	Zip		

### 3. Medical, Dental and Vision Plan Selection

Write in a plan selection for Medical, Dental & Vision. You can Opt Out or Waive Medical or Decline any coverage.

If you **decline** Dental and/or Vision coverage when initially eligible, then you choose to enroll in one or both of these plans at a future Open Enrollment period, you and any dependents enrolled will be subject to a 12-month waiting period on these plans (meaning only preventive and routine services will be covered during the first 12 months of coverage).

<b>Medical Benefit Plan Selection:</b>	_____	<input type="checkbox"/> Opt Out of Medical*	<input type="checkbox"/> Waive Medical*
<b>Dental Benefit Plan Selection:</b>	_____	<input type="checkbox"/> Decline Dental	
<b>Vision Benefit Plan Selection:</b>	_____	<input type="checkbox"/> Decline Vision	

\* "Opt Out" indicates you have other group medical coverage AND receive a financial incentive for declining OEBB medical coverage. "Waive" indicates you decline OEBB medical coverage without receiving a financial incentive to do so, regardless of other coverage. **Note: Many educational entities do not offer a financial incentive – in those cases you may not "opt out".** If your educational entity does offer a financial incentive and you wish to "Opt Out", you must complete section 4.

### 4. Other Group Coverage

To Opt Out of Medical coverage you must complete this section and provide proof of other group coverage to your educational entity within five business days or your opt out election will not be effective.

Plan	Carrier	Policy Number	Group Number
Plan Type: <input type="checkbox"/> Medical			
Principal Enrollee in Other Group Plan	Employer	Effective Date _ _ / _ _ / _ _ _ _	

## 5. Optional Insurance

Benefit options in section 5 depend on your Educational Entity. Two things to consider:

1. Your entity may automatically enroll you in a coverage amount for basic life insurance and/or basic AD&D.
2. Your entity determines which optional benefits it will offer and may not offer all the benefits on this form.

Contact your educational entity for coverage information and to find out which benefits are available to you.

<b>Employee Optional Life Insurance</b> (\$10,000 increments, maximum \$500,000)		Guarantee Issue (medical history is <b>not</b> required) <input type="checkbox"/> \$ _____ (up to \$200,000)
<b>New Enrollment*</b>	<b>Change Current Coverage*</b>	<b>Decline Coverage</b>
Total Requested Amount: \$ _____	Increase to \$ _____ Decrease to \$ _____	<input type="checkbox"/>

<b>Spouse or Domestic Partner Optional Life Insurance</b> (\$10,000 increments, maximum \$500,000)		Guarantee Issue (medical history is <b>not</b> required) <input type="checkbox"/> \$ _____ (up to \$30,000)
Total requested amount must be equal to or less than employee optional life insurance coverage.		
<b>New Enrollment*</b>	<b>Change Current Coverage*</b>	<b>Decline Coverage</b>
Total Requested Amount: \$ _____	Increase to \$ _____ Decrease to \$ _____	<input type="checkbox"/>

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

<b>Child or Children Optional Life Insurance</b> (\$2,000 increments, maximum \$10,000) Medical history is not required. You must enroll in employee optional life to enroll your child or children in this coverage.		
<b>New Enrollment</b>	<b>Change Current Coverage</b>	<b>Decline Coverage</b>
Total Requested Amount: \$ _____	Increase to \$ _____ Decrease to \$ _____	<input type="checkbox"/>

<b>Employee Optional Accidental Death and Dismemberment (AD&amp;D)</b> (\$10,000 increments, maximum \$500,000) Medical history is not required.		
<b>New Enrollment</b>	<b>Change Current Coverage</b>	<b>Decline Coverage</b>
Total Requested Amount: \$ _____	Increase to \$ _____ Decrease to \$ _____	<input type="checkbox"/>

<b>Spouse or Domestic Partner Optional Accidental Death and Dismemberment (AD&amp;D)</b> (\$10,000 increments, maximum \$500,000) Medical history is not required.		
Total requested amount must be equal to or less than employee optional AD&D coverage.		
<b>New Enrollment</b>	<b>Change Current Coverage</b>	<b>Decline Coverage</b>
Total Requested Amount: \$ _____	Increase to \$ _____ Decrease to \$ _____	<input type="checkbox"/>

<b>Child Optional Accidental Death and Dismemberment (AD&amp;D)</b> (\$2,000 increments, maximum \$10,000) Medical history is not required.		
<b>New Enrollment</b>	<b>Change Current Coverage</b>	<b>Decline Coverage</b>
Total Requested Amount: \$ _____	Increase to \$ _____ Decrease to \$ _____	<input type="checkbox"/>

## 6. Beneficiary Designation

Total of primary percentages must = 100%.  
Total of contingent percentages must = 100%.

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.

Name	Address	Relationship	Primary	Contingent	Whole %
			<input type="checkbox"/>	or <input type="checkbox"/>	%
			<input type="checkbox"/>	or <input type="checkbox"/>	%

## 7. Voluntary Disability Insurance

Benefit options in section 8 depend on your Educational Entity. Two things to consider:

1. Your entity may automatically enroll you in a disability plan.
2. Your entity determines which disability plan it will offer and may not offer all the benefits on this form.

Contact your educational entity for coverage information and to find out which benefits are available to you.

<b>Voluntary Short Term Disability</b>	<input type="checkbox"/> Enroll for Coverage	<input type="checkbox"/> Decline Coverage
<b>Voluntary Long Term Disability</b>	<input type="checkbox"/> Enroll for Coverage	<input type="checkbox"/> Decline Coverage

**OEBB also offers Long Term Care Insurance. Contact your educational entity to find out if you may enroll.**

## 8. Employee Signature and Authorization

I declare the dependents listed above and I am 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](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](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](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/docs/QSCs/QSCMatrix.pdf>

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 completed form to your Educational Entity. Do not submit this form to OEBB.**