Open Enrollment Change Form

Use this form to update your benefits during Open Enrollment.

Educational Entity Use Only	
Approved by ___________	**Date**_______________
Effective Date ______________________________	

In most cases, changes will go into effect October 1st. If you are requesting coverage which requires carrier approval, coverage will go into effect the first of the month following carrier approval or October 1st, whichever is later.

1. What changes would you like to make? Mark all that apply.

☐ Add a dependent	☐ Decline OEBB benefits	☐ Change my current plan enrollments
☐ Remove a dependent (If a dependent is losing eligibility, use the Midyear Change Form to ensure their continuation rights.)	☐ Enroll in OEBB benefits	☐ Opt out or Waive OEBB Medical **(must complete Section 8)**

2. Employee Information

Educational Entity	Employee ID, SSN, or E Number

Last Name	First Name	MI	Date of Birth (mm/dd/yyyy)	Gender ☐ M ☐ F

Ethnicity (select one): ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race (select one or more, circle one as primary): ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Refused ☐ Unknown

Residence Address ☐ Check if New Address	Apt #	City	State	Zip

Mailing Address (if different from Residence Address)	City	State	Zip

Home Phone	Work Phone	Ext.	Personal E-mail	Work E-mail

3. Dependent Information

Attach separate sheet if necessary.

Relationship Codes ("Rel. Code" below – Please indicate one per dependent.)
SP=Spouse, **CH**=Employee and/or Spouse's child, **DD**=Disabled Dependent, **DP**=Domestic Partner, **DP CH**=Domestic Partner's Child

Ethnicity Codes (Please indicate one per dependent below.)
1=Hispanic, **2**=Non-Hispanic/Non-Latino, **3**=Refused, **4**=Unknown

Race Codes (Please indicate one or more per dependent below. If more than one, please indicate one primary race in the next column.)
1=Asian, **2**=Black/African American, **3**=American Indian/Alaskan Native, **4**=Native Hawaiian/Other Pacific Islander, **5**=White, **6**=Other, **7**=Refused, **8**=Unknown

Due to Federal Health Care Reform, OEBB is requesting Ethnicity, Race and Primary Race information for all members and dependents. Please indicate one ethnicity code for each dependent and at least one race code for each dependent. If indicating more than one race code for a dependent, please also indicate in the next column which one of those race codes is the dependent's primary race.

Last Name	First Name	M.I.	Birth Date (mm/dd/yyyy)	Rel. Code	Gender		Ethnicity Code	Race Code(s)	Primary Race	Enroll				
					M	F				Med	Den	Vision	Add	Drop
					☐	☐				☐	☐	☐	☐	☐
Address for dependent above (if different than Section 2):														
					☐	☐				☐	☐	☐	☐	☐
Address for dependent above (if different than Section 2):														
					☐	☐				☐	☐	☐	☐	☐
Address for dependent above (if different than Section 2):														
					☐	☐				☐	☐	☐	☐	☐
Address for dependent above (if different than Section 2):														

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. If you do not report this change on time, OEBB may consider your omission as an intentional misrepresentation of a material fact, for which OEBB may terminate the dependent's coverage effective the first of the month after eligibility was lost.

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 not be effective.

4. Medical, Dental and Vision Plan Selection

Leave blank if you are not changing your plan selection.

Medical Benefit Plan Selection: ______________________________ ☐ Opt Out of Medical* ☐ Waive Medical*

Dental Benefit Plan Selection: ______________________________ ☐ Decline Dental

Vision Benefit Plan Selection: ______________________________ ☐ Decline Vision

*To Opt Out, you must complete section 8. "Opt Out" means you receive a financial incentive, "Waive" means you do not receive a financial incentive.

5. Optional Life and Accidental Death & Dismemberment (AD&D) Insurance

Your benefit choices 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.

Employee Optional Life Insurance

($10,000 increments, maximum $500,000)

Newly Eligible ONLY: ☐ $____________ (up to $200,000)
Guarantee Issue (medical history is **not** required)

New Enrollment*	Change Current Coverage*	Cancel Coverage
Total Requested Amount: $____________	Increase to $____________ Decrease to $____________	☐

Spouse or Domestic Partner Optional Life Insurance

($10,000 increments, maximum $500,000)
Total requested amount must be equal to or less than employee optional life insurance coverage.

Newly Eligible ONLY: ☐ $____________ (up to $30,000)
Guarantee Issue (medical history is **not** required)

New Enrollment*	Change Current Coverage*	Cancel Coverage
Total Requested Amount: $____________	Increase to $____________ Decrease to $____________	☐

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

Child or Children Optional Life Insurance

($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.

New Enrollment	Change Current Coverage	Cancel Coverage
Total Requested Amount: $____________	Increase to $____________ Decrease to $____________	☐

Employee Optional Accidental Death and Dismemberment (AD&D)

($10,000 increments, maximum $500,000) Medical history is not required.		
New Enrollment **Total** Requested Amount: $______________	**Change Current Coverage** Increase to $________________ Decrease to $________________	**Cancel Coverage** ☐

Spouse or Domestic Partner Optional Accidental Death and Dismemberment (AD&D)

($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.

New Enrollment	Change Current Coverage	Cancel Coverage
Total Requested Amount: $______________	Increase to $________________ Decrease to $________________	☐

Child Optional Accidental Death and Dismemberment (AD&D)

($2,000 increments, maximum $10,000) Medical history is not required.

You must enroll in employee optional AD&D to enroll your child or children in this coverage.

New Enrollment	Change Current Coverage	Cancel Coverage
Total Requested Amount: $______________	Increase to $________________ Decrease to $________________	☐

6. Beneficiary Designation

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

I elect: ☐ The **Standard Order of Survivorship** (no beneficiary listed)
☐ To designate the following as beneficiary (attach additional sheets if necessary)

Name	Address	Relationship	Primary Contingent	Whole %
			☐ or ☐	%
			☐ or ☐	%
			☐ or ☐	%

7. Voluntary Disability Insurance

Your benefit choices in section 7 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 plans 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 you may enroll in.

Voluntary Short Term Disability	Voluntary Long Term Disability
☐ Enroll for Coverage	☐ Enroll for Coverage
☐ Cancel Coverage	☐ Cancel Coverage

8. 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 Type:	Plan	Carrier	Policy Number	Group Number
	☐ Medical			
Principal Enrollee in Other Group Plan			Employer	Effective Date _ _ / _ _ / _ _ _ _

9. Medicare Eligibility

Attach a separate sheet if necessary. **The following individuals are eligible for Medicare due to age or disability:**

☐ No one listed on this form is eligible for Medicare.	☐ Self	☐ My Spouse or Domestic Partner Name: ____________________ SSN/HICN: ____________________	☐ A Dependent Child Name: ____________________ SSN/HICN: ____________________

10. 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/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

Active Employees and Early Retirees: Send this completed form to your educational entity. Do **not** mail this form to OEBB.

COBRA participants: Send this completed form to BenefitHelp Solutions (BHS), P.O. Box 67230, Portland, OR 97268-1230