



Medical, Dental, and Vision Enrollment and Change Form Active Employee and Retiree Plan Year 2008

New Hire
 Change
 Open Enrollment

SECTION A - EMPLOYEE INFORMATION

School District Name: _____ Date of Hire: _____ Effective Date: _____

Employee Name: (Print) _____ Employee ID, SSN, E #: _____

Employee Date of Birth: _____ Male Female Phone: (H) _____ (W) _____

Employee Address: _____
City
State
Zip

Mailing Address: (if different from above) _____ E-mail _____

Dependent Address: (if different from above) _____

Employee Classification:	<input type="checkbox"/> Admin/Conf	<input type="checkbox"/> Licensed	<input type="checkbox"/> Classified
Employee Status:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Retired <input type="checkbox"/> COBRA
Employee Affiliation:	<input type="checkbox"/> OEA	<input type="checkbox"/> OSEA	<input type="checkbox"/> AFT-Oregon <input type="checkbox"/> Non-Rep
Qualified Status Change:	<input type="checkbox"/> New Hire	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption
Date: _____	<input type="checkbox"/> Dependent meets eligibility	<input type="checkbox"/> Qualified Domestic Partner	
	<input type="checkbox"/> Dependent ceases to meet eligibility	<input type="checkbox"/> Death of spouse/dependent	
	<input type="checkbox"/> National Medical Support Notice	<input type="checkbox"/> Employment status change	
	<input type="checkbox"/> Gain/Loss of Other Group Coverage	<input type="checkbox"/> Other _____	

SECTION B - MEDICAL, DENTAL, AND VISION PLAN ELECTIONS

Medical Benefit Plan Selection _____

Dental Benefit Plan Selection _____

Vision Benefit Plan Selection _____

ALTERNATIVE CHOICE:

MEDICAL OPT OUT

You must have other group coverage to be eligible.
Complete Section D.

I wish to waive the following benefits:

MEDICAL **DENTAL** **VISION**

SECTION C - DEPENDENT INFORMATION AND PLAN SELECTION

For new enrollment, indicate all eligible dependents you wish to cover and check the plan offerings in which you will enroll your dependents. For changes, indicate whether you are adding or dropping the dependent(s) and list their information. If covering a domestic partner without a certificate, partner's children, or dependent by affidavit, a completed affidavit must be attached or on file (check with your district or educational entity for eligibility)

Relationship Key: **SP** = Spouse, **DPA** = Domestic Partner by Affidavit, **DPC** = Domestic Partner by Certificate,

CH = Employee and/or Spouse's child, **DPCH** = Domestic Partner's child, **AFFCH** = Child by Affidavit

DD = Disabled Dependent

Add / Drop + / -	Last Name	First Name	MI	Birth Date (MM-DD-YY)	Relationship	Gender		Plan		
						M	F	Med	Den	Vision
						<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C.1 Dependent certification Detailed eligibility information is available at:
www.oregon.gov/DAS/OEBB

I certify that all my dependent child(ren) between the ages of 19 and up to age 26 meet the eligibility requirements for enrollment in the OEBB plans. **Please consult your district regarding restrictions for eligibility of overage dependents.**

C.2 Domestic Partner - Check the appropriate box.

- Domestic Partner by OEBB Affidavit of Domestic Partnership (attach Affidavit to this form)
 Domestic Partner by Certificate of Registered Domestic Partnership

Please consult your district regarding restrictions for eligibility of opposite sex Domestic Partners.

SECTION D - OTHER GROUP COVERAGE INFORMATION

Are you or any of your dependents covered through another OEBB or group plan? Yes No
If yes, please complete the following information:
Check which plan: Medical

Carrier

Policy Number

Group Number

Effective Date

Subscriber's Name

Employer

Medicare Information

- I am covered by Medicare My dependent(s) is covered by Medicare

SECTION E - EMPLOYEE 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 OEBB's eligibility requirements, or until I elect to change them subject to the provisions of OEBB's plan. 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.

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 form supersedes all forms 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

"Educational Entity Use Only"

Approved by (initials):

Approved change effective date:

Date:

MyOEBB updated by (initials):

Upon completion, please return this form to your Educational Entity Benefits/Payroll office. Do not mail this form to OEBB. If mailed to OEBB, it will be returned to your Educational Entity and could cause a delay in benefits.