

1. Employee Information

Social Security Number		L#	
Last Name	First Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address		City	State Zip
Preferred Phone	If cell phone, do you wish to receive text message reminders from OEBB? <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Email	
Are you eligible for Medicare due to age or disability? <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 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 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"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			

2. 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.

Dependent A	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Medicare Eligible	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Race/Ethnicity:			
Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Dependent B	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Medicare Eligible	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Race/Ethnicity:			
Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Dependent C	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Medicare Eligible	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Race/Ethnicity:			
Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Dependent D	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Medicare Eligible	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Race/Ethnicity:			
Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	

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.

3. Tobacco Usage

This information will be used to determine your premium amount(s) for Optional Employee and Optional Spouse/Domestic Partner Life plans.	Please select one of the following:	Please select one of the following:
	<input type="checkbox"/> I currently use tobacco products. <input type="checkbox"/> I have not used tobacco products in the past 12 months. <input type="checkbox"/> I have never used tobacco products.	<input type="checkbox"/> I do not currently have a spouse or domestic partner. <input type="checkbox"/> My spouse/domestic partner currently uses tobacco products. <input type="checkbox"/> My spouse/partner has not used tobacco products in the past 12 months. <input type="checkbox"/> My spouse/domestic partner has never used tobacco products.

4. Medical, Dental and Vision Plan Selection

Indicate a selection for each plan type.

Medical Benefit Plan Selection	<input type="checkbox"/> Moda Plan 1 <input type="checkbox"/> Moda Plan 2 <input type="checkbox"/> Moda Plan 6 (w/ optional HSA) <input type="checkbox"/> Kaiser Plan 1	<input type="checkbox"/> Decline Medical Explanation (required if declining; attach proof of other coverage if opting out to receive stipend):
Dental Benefit Plan Selection	<input type="checkbox"/> Delta Dental Plan 1 <input type="checkbox"/> Delta Dental Plan 6 <input type="checkbox"/> Willamette Dental Plan	<input type="checkbox"/> Decline Dental*
Vision Benefit Plan Selection	<input type="checkbox"/> Moda Opal <input type="checkbox"/> VSP Choice Plus	<input type="checkbox"/> Decline Vision

*If you waive benefit coverage now, you may be subject to waiting period restrictions at a later date.

5. Voluntary Life Insurance

All coverage elections above the guarantee issue amount and/or beyond the guarantee issue period must be medically underwritten. Please mark the box for all coverage(s) you are applying for. By selecting "no", an application for coverage at a later date may require further medical information and/or physical exam, which may be at the member's own expense.

Voluntary Employee Coverage <input type="checkbox"/> Life Only (in \$10,000 increments): \$ _____ <input type="checkbox"/> Life & AD&D (in \$10,000 increments): \$ _____ <i>\$200,000 Guarantee Issue</i> <i>\$500,000 Maximum Coverage</i> Employees must elect coverage in order to elect spouse/partner and/or dependent coverage. Total employee amount must be equal to or greater than requested amount for spouse/partner coverage.	Voluntary Spouse/Domestic Partner Coverage <input type="checkbox"/> Life Only (in \$10,000 increments): \$ _____ <input type="checkbox"/> Life & AD&D (in \$10,000 increments): \$ _____ <i>\$30,000 Guarantee Issue</i> <i>\$500,000 Maximum Coverage</i>
	Voluntary Dependent Child Coverage <input type="checkbox"/> Life Only (in \$2,000 increments): \$ _____ <input type="checkbox"/> Life & AD&D (in \$2,000 increments): \$ _____ <i>\$10,000 Maximum Coverage</i>

Beneficiary Information

A contingent beneficiary will receive benefits only if the primary beneficiary does not survive you.

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

6. Voluntary Long Term Care

All employee coverage elections above the guarantee issue amount and/or beyond the guarantee issue period must be medically underwritten. Additionally, all spouse/partner coverage must be medically underwritten. Please contact Human Resources to obtain the application for this process.

<input type="checkbox"/> Employee Coverage: Monthly Coverage (in \$1000 increments): \$ _____ Duration (check one): 3-Years 6-Years Lifetime Simple Inflation (check one): with without Total Home Care (check one): with without	<input type="checkbox"/> Spouse/Partner Coverage: Monthly Coverage (in \$1000 increments): \$ _____ Duration (check one): 3-Years 6-Years Lifetime Simple Inflation (check one): with without Total Home Care (check one): with without
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7. Employee Signature and Authorization

I declare the dependents listed above and I am eligible for the coverages requested per OEBC 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 OEBC's eligibility requirements, or until I elect to change them subject to the provisions of OEBC'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 OEBC QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix at

<http://www.oregon.gov/oha/OEBC/Pages/QSC-Matrix.aspx>

I have read the benefit materials and I understand the limitations and qualifications of the OEBC 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 OEBC 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 OEBC 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 _____

HUMAN RESOURCES USE ONLY

Coverage Effective Date _____

OEBC E # _____

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Infinisource