



# Medical, Dental, and Vision Enrollment and Change Form

## Active Employee and Retiree Plan Year 2009

New Hire     
  Change     
  Open Enrollment

**SECTION A - EMPLOYEE INFORMATION**

School District Name: \_\_\_\_\_ Employee ID, SSN, E #: \_\_\_\_\_  
 Employee Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
 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	<input type="checkbox"/> Superintendent
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
	<input type="checkbox"/> OACE			
Qualified Status Change:	<input type="checkbox"/> New Hire	<input type="checkbox"/> Marriage	<input type="checkbox"/> Meets Domestic Partner eligibility	
Date: _____	<input type="checkbox"/> Divorce	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Termination of Domestic Partnership	
	<input type="checkbox"/> Dependent meets eligibility		<input type="checkbox"/> Death of spouse/dependent	
	<input type="checkbox"/> Dependent ceases to meet eligibility		<input type="checkbox"/> Move causes loss of eligibility	
	<input type="checkbox"/> Qualified Medical Child Support Order		<input type="checkbox"/> Employment status change which affects eligibility	
	<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/decline 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](http://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 coverage 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

#### SECTION E - MEDICARE INFORMATION (only complete if Medicare eligible)

I am covered by Medicare

My dependent(s) is covered by Medicare\*

\* In order to maintain benefits for your Medicare eligible dependent, please provide to your employer **one** of the following:

Social Security Number (SSN) \_\_\_\_\_ Medicare Claim Number (HICN) \_\_\_\_\_

Refusal to Provide Requested Information

#### SECTION F - 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):

If you are an **active employee or retiree**: 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.

If you are benefits eligible due to HB 2557 and enrolling in benefits or making a change, please mail this completed form to: OEBB, 1225 Ferry Street SE, Salem, OR 97301