2018–19 Plan Year
HB 2557 Member Enrollment Form

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

Member information

Last name	First name		Middle
E number or Social Security Number		Gender ☐ M ☐ F	Date of birth *(mm/dd/yyyy)*
Home phone number	Work phone number		Cell phone number
May OEBB send text messages to this number? Standard text message and data rates apply. ☐ Yes ☐ No			
Personal email	Work email		
Address ☐ Check if new address			Apartment or space#
City	State	ZIP	County
Medicare eligible? ☐ Yes ☐ No	**Are you serving or did you ever serve in the military?** ☐ Yes ☐ No		
If "Yes," do you authorize OEBB to send your name and address to the Oregon Department of Veterans' Affairs (ODVA) for the purpose of receiving benefit information? ☐ Yes ☐ No			
Ethnicity *(Select one):* ☐ Hispanic	☐ Non-Hispanic/Non-Latino	☐ Refused	☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*

☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Tobacco usage *(Responses in this section are required)*

Member	**Spouse/Domestic partner**
In the last 12 months *(Select one)*:	In the last 12 months *(Select one)*:
☐ I have used tobacco products	☐ I do not currently have a spouse/domestic partner
☐ I have ***not*** used tobacco products	☐ My spouse/domestic partner has used tobacco products
☐ I have never used tobacco products	☐ My spouse/domestic partner has ***not*** used tobacco products
	☐ My spouse/domestic partner has never used tobacco products

Dependent information *(Attach additional sheets if necessary)*

You must report to OEBBs' HB2557 Coordinator within 31 days after a person enrolled as your spouse/domestic partner or dependent child becomes ineligible for benefits. 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 members' 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 *(Copy not required)*

* Affidavit Information: If you are adding a domestic partner by OEBB Affidavit, you must submit the affidavit to OEBB within five business days of this enrollment or the individual's coverage will not be effective. OEBB's Affidavit of Domestic Partnership can be found online at: http://www.oregon.gov/oha/OEBB/pages/Forms.aspx.

Dependent A

Enroll: ☐ Medical

Relationship to member: ☐ Spouse ☐ Domestic partner ☐ Child

Gender: ☐ M ☐ F

Date of birth: *(mm/dd/yyyy)*

Social Security, HICN, or Tax ID Number:

Medicare eligible?* ☐ Yes ☐ No

Last name:

First name:

Middle:

Address *(if different from member address):*

City:

State:

ZIP:

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

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ White ☐ Black/African American ☐ Refused ☐ Unknown ☐ Other
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

Dependent B

Enroll: ☐ Medical

Relationship to member: ☐ Spouse ☐ Domestic partner ☐ Child

Gender: ☐ M ☐ F

Date of birth: *(mm/dd/yyyy)*

Social Security, HICN, or Tax ID Number:

Medicare eligible?* ☐ Yes ☐ No

Last name:

First name:

Middle:

Address *(if different from member address):*

City:

State:

ZIP:

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

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ White ☐ Black/African American ☐ Refused ☐ Unknown ☐ Other
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

Dependent C Enroll: ☐ Medical

Relationship to member: ☐ Spouse ☐ Domestic partner ☐ Child

Gender: ☐ M ☐ F | Date of birth: *(mm/dd/yyyy)* | Social Security, HICN, or Tax ID Number: | Medicare eligible?* ☐ Yes ☐ No

Last name: | First name: | Middle:

Address *(if different from member address):* | City: | State: | ZIP:

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

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ White ☐ Black/African American ☐ Refused ☐ Unknown ☐ Other
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

Medical plan selection

Check the box for the plan you are selecting to enroll in.

PPO Connexus	CCM Synergy/ CCM Summit	HMO
☐ Cedar Plan	☐ Cedar Plan†	☐ Medical Plan 3†
☐ Dogwood Plan	☐ Dogwood Plan†	
☐ Evergreen Plan	☐ Evergreen Plan†	

† You must live in an eligible county to enroll in a Moda Health CCM Synergy/CCM Summit Plan or Kaiser HMO Medical Plan 3. If selecting a Moda Health CCM Synergy/ Summit Plan, prior to the coverage start date you must contact Moda Health to select a Medical Home Provider for each covered member. A list of Medical Home Providers can be found at: https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml

Member signature and authorization

I declare the dependents listed above and I are eligible for the coverages requested per OEBB Administrative Rule (OAR)-Division. 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 OEBB's HB2557 Coordinator 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 experience a QSC; then I am subject to the restrictions of the OEBB QSCs. I have reviewed and understand the Qualified Status Change (QSC) Matrix which can be found at:

http://www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx

I have read the benefit materials and I understand the limitations and qualifications of the OEBB benefits program. This is a self-pay program, I agree for monthly payments to be deducted from my financial institution by the date specified on the back of the ACH form, or my coverage will terminate. I will not be able to reinstate coverage until the next open enrollment period (if I requalify) or I 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.

Member signature

Date

Submit your completed form to:

By Mail: OEBB, HB 2557 Enrollment
500 Summer Street NE, E-88
Salem, OR 97301-1063

Phone: 1-888-469-6322
Fax: 503-378-5832