2018–19 Plan Year
Self-Pay Early Retiree (SPER)
Open Enrollment Form
No Optional Plans

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

Use this form to make plan selections during Open Enrollment. Plan elections or changes will go into effect October 1, 2018. During Open Enrollment, allowable changes are:

- Continuing or cancelling medical, dental, and/or vision coverage (selection of different plan allowed)
- Continuing or cancelling optional plans available, and
- Removing an eligible dependent from coverage.

As a Self-Pay Early Retiree (SPER), any dependent removed or coverage waived/declined is not eligible to be added back at a future open enrollment period.

SPER information

Last name	First name		Middle
E number or Social Security Number		Gender ☐ M ☐ F	Date of birth *(mm/dd/yyyy)*
Primary phone number		Cell phone number	
May OEBB send text messages to this number? Standard text message and data rates apply.			☐ Yes ☐ No
Address ☐ Check if new address			Apartment or space#
City	State		ZIP
County	Email		
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

*** Warning: All SPERs and dependents of SPERs lose eligibility for OEBB plans on the day they become eligible for Medicare due to age 65 or disability (regardless of whether you enroll in Medicare coverage). Notify OEBB immediately if you or your dependent is eligible for Medicare. If dropping coverage for you or a dependent it cannot be added back at a future date without a qualifying event. See QSC Matrix for details.**

Dependent information *(Attach additional sheets if necessary)*

You must report to OEBB 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 ☐ Change enrollment ☐ Remove dependent | Remove: ☐ Medical ☐ Vision ☐ Dental

Relationship to SPER: ☐ 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 SPER 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 ☐ Change enrollment ☐ Remove dependent | Remove: ☐ Medical ☐ Vision ☐ Dental

Relationship to SPER: ☐ 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 SPER 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 ☐ Change enrollment ☐ Remove dependent | Remove: ☐ Medical ☐ Vision ☐ Dental

Relationship to SPER: ☐ 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 SPER 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

Plan selection

You can waive Medical or Decline Dental and/or Vision. If you are not currently enrolled in Medical, Dental, and/or Vision, you are not eligible to re-enroll.

Medical

Medical Plan Selection: _____ ☐ Waive Medical

Write in plan selection.

If selecting a Moda Medical CCM Synergy/CCM Summit Plan prior to the coverage start date, you must contact Moda Health to select a Medical Home Provider for each covered SPER. A list of Medical Home Providers can be found at:

https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml

Vision

Vision Plan Selection: _____ ☐ Decline Vision

Write in plan selection *(Must be enrolled in Kaiser HMO Medical to enroll in Kaiser Vision).*

Dental

Dental Plan Selection: _____ ☐ Decline Dental

Write in plan selection.

SPER 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 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.

SPER signature

Date

Submit this form to OEBB by September 15, 2018

By mail: OEBB
Attn: SPER Enrollment
500 Summer Street NE, E-88
Salem, OR 97301-1063

By fax: 503-378-5832