



2018–19 Plan Year Self-Pay Early Retiree (SPER) Open Enrollment Form

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

As a Self-Pay Early Retiree (SPER), any eligible 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 <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (<i>mm/dd/yyyy</i>)	
Primary phone number	Cell phone number		
May OEGB send text messages to this number? Standard text message and data rates apply.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Address	<input type="checkbox"/> Check if new address		Apartment or space#
City	State	ZIP	
County	Email		
Medicare eligible?* <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 OEGB to send your name and address to the Oregon Department of Veterans’ Affairs (ODVA) for the purpose of receiving benefit information?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Ethnicity (<i>Select one</i>): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			
Race (<i>Select at least one. If selecting more than one, circle one as primary</i>):			
<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Other	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown

*** Warning! All SPERs and dependents of SPERs lose eligibility for OEGB plans on the day they become eligible for Medicare due to age 65 or disability. Notify OEGB immediately if you or your dependent is eligible for Medicare, regardless of whether you enroll in Medicare coverage. 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.**

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

Member

In the last 12 months *(Select one)*:

- I have used tobacco products
 I have **not** used tobacco products
 I have never used tobacco products

Spouse/Domestic partner

In the last 12 months *(Select one)*:

- I do not currently have a spouse/domestic partner
 My spouse/domestic partner has 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 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	<input type="checkbox"/> Change enrollment <input type="checkbox"/> Remove dependent	Remove: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental
Relationship to SPER: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child		
Gender: Date of birth: <i>(mm/dd/yyyy)</i>	Social Security, HICN, or Tax ID Number:	Medicare eligible?*
<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No
Last name:	First name:	Middle:
Address <i>(if different from SPER address)</i> :		City: State: ZIP:
Ethnicity <i>(Select one)</i> :	Race <i>(Select at least one. If selecting more than one, circle one as primary)</i> :	
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
<input type="checkbox"/> Refused <input type="checkbox"/> Unknown	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	

Dependent B	<input type="checkbox"/> Change enrollment <input type="checkbox"/> Remove dependent	Remove: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental
Relationship to SPER: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child		
Gender: Date of birth: <i>(mm/dd/yyyy)</i>	Social Security, HICN, or Tax ID Number:	Medicare eligible?*
<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No
Last name:	First name:	Middle:
Address <i>(if different from SPER address)</i> :		City: State: ZIP:
Ethnicity <i>(Select one)</i> :	Race <i>(Select at least one. If selecting more than one, circle one as primary)</i> :	
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
<input type="checkbox"/> Refused <input type="checkbox"/> Unknown	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	

Dependent information *(Attach additional sheets if necessary)*

Dependent C	<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Remove dependent	Remove:	<input type="checkbox"/> Medical	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental	
Relationship to SPER: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child							
Gender:	Date of birth: <i>(mm/dd/yyyy)</i>	Social Security, HICN, or Tax ID Number:			Medicare eligible?*		
<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Last name:		First name:		Middle:			
Address <i>(if different from SPER address)</i> :				City:	State:	ZIP:	
Ethnicity <i>(Select one):</i>			Race <i>(Select at least one. If selecting more than one, circle one as primary):</i>				
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other
<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> 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

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

Dental

Medical plan selection: _____ Decline Dental
Write in plan selection.

Optional plans

If a SPER and their dependents are enrolled in Optional Life and/or Optional AD&D, the enrollments may be continued, decreased, or canceled (subject to plan availability as determined by their former employer). Any canceled or decreased coverage cannot be added back at a later date.

Optional Life Insurance

Employee (SPER) Optional Life Insurance	<input type="checkbox"/> Continue enrollment	<input type="checkbox"/> Decline coverage
Decrease enrollment to \$ _____ (\$10,000 increments)		
Spouse/Domestic Partner Optional Life Insurance	<input type="checkbox"/> Continue enrollment	<input type="checkbox"/> Decline coverage
Decrease enrollment to \$ _____ (\$10,000 increments)		
Total requested amount must be equal to or less than SPER optional life insurance coverage.		
Child(ren) Optional Life Insurance	<input type="checkbox"/> Continue enrollment	<input type="checkbox"/> Decline coverage
Decrease enrollment to \$ _____ (\$2,000 increments)		
SPER must be enrolled in (SPER) optional life for children to remain enrolled.		

Optional Accidental Death & Dismemberment (AD&D) Insurance

Employee (SPER) Optional AD&D Insurance	<input type="checkbox"/> Continue enrollment	<input type="checkbox"/> Decline coverage
Decrease enrollment to \$ _____ (\$10,000 increments)		
Spouse/Domestic Partner Optional AD&D Insurance	<input type="checkbox"/> Continue enrollment	<input type="checkbox"/> Decline coverage
Decrease enrollment to \$ _____ (\$10,000 increments)		
Total requested amount must be equal to or less than SPER optional life insurance coverage.		
Child(ren) Optional AD&D Insurance	<input type="checkbox"/> Continue enrollment	<input type="checkbox"/> Decline coverage
Decrease enrollment to \$ _____ (\$2,000 increments)		
SPER must be enrolled in (SPER) optional life for children to remain enrolled.		

Beneficiary designation

- I elect:** The Standard Order of Survivorship (If you have a Domestic Partner, an Affidavit* must be on file for distribution.)
 To designate the following as beneficiary (Attach additional sheets if necessary.)

Total of primary percentages must = 100%

Total of contingent percentages must = 100%

Name	Address				
City	State	ZIP	Relationship	Primary or Contingent	Whole%
				<input type="checkbox"/> OR <input type="checkbox"/>	
Name	Address				
City	State	ZIP	Relationship	Primary or Contingent	Whole%
				<input type="checkbox"/> OR <input type="checkbox"/>	
Name	Address				
City	State	ZIP	Relationship	Primary or Contingent	Whole%
				<input type="checkbox"/> OR <input type="checkbox"/>	

*Affidavit Information: OEBB's Affidavit of Domestic Partnership can be found online at: <http://www.oregon.gov/oha/OEBB/pages/Forms.aspx>

SPER signature and authorization

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

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

I have read the benefit materials and I understand the limitations and qualifications of the OEGB 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 OEGB 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 OEGB 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 OEGB by September 15, 2018

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

By fax: 503-378-5832