IRS Notice 2020-29 Midyear Change Form

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

Use this form to update your benefits no later than June 30, 2020. Forms received after this date will not be processed.
These plan elections or changes will go into effect the first of the month after this form is received

Employee information

Last name	First name		Middle
Employee ID, E number or Social Security number		Gender ◯ M ◯ F ◯ Other	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			
Address ☐ Check if new address			Apartment or space#
City		State ZIP	County
Personal email		Work 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)*:

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

IRS Notice 2020-29 change event *(check all that apply)*

A. Medical

☐ Add medical plan ☐ Add dependent(s) to medical plan ☐ Opt-out of medical ☐ Waive medical

B. Dental

☐ Add dental plan ☐ Add dependent(s) to dental plan

C. Vision

☐ Add vision plan ☐ Add dependent(s) to vision plan

Dependent information

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 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)*

* Domestic partner eligibility rules may vary by employer — verify with your benefits administrator before enrolling.
**Affidavit Information: If you are adding a domestic partner by OEBB Affidavit, you must submit the affidavit to your employer 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 ☐ Vision ☐ Dental

Relationship to employee ◯ Spouse ◯ Domestic partner ◯ Child

Gender ◯ M ◯ F ◯ Other | Date of birth *(mm/dd/yyyy)* | Social Security, HICN, or Tax ID number: | Medicare eligible? ◯ Y ◯ N

Last name | First name | Middle

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

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

Dependent B ☐ Enroll ☐ Medical ☐ Vision ☐ Dental

Relationship to employee ◯ Spouse ◯ Domestic partner ◯ Child

Gender ◯ M ◯ F ◯ Other | Date of birth *(mm/dd/yyyy)* | Social Security, HICN, or Tax ID number: | Medicare eligible? ◯ Y ◯ N

Last name | First name | Middle

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

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

Dependent C ☐ Enroll ☐ Medical ☐ Vision ☐ Dental

Relationship to employee ◯ Spouse ◯ Domestic partner ◯ Child

Gender ◯ M ◯ F ◯ Other | Date of birth *(mm/dd/yyyy)* | Social Security, HICN, or Tax ID number: | Medicare eligible? ◯ Y ◯ N

Last name | First name | Middle

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

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

Dependent D ☐ Enroll ☐ Medical ☐ Vision ☐ Dental

Relationship to employee ◯ Spouse ◯ Domestic partner ◯ Child

Gender ◯ M ◯ F ◯ Other | Date of birth *(mm/dd/yyyy)* | Social Security, HICN, or Tax ID number: | Medicare eligible? ◯ Y ◯ N

Last name | First name | Middle

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

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

Health Care plan selections

Medical

Medical plan selection: _____

Write in plan selection

If enrolled in a Moda medical plan, each covered individual must choose a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit if using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive the "non-coordinated" benefit if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level regardless of whether or not the individual has chosen a PCP 360 with Moda. A list of PCP 360 providers can be found at:

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

If you are choosing to not enroll in an OEBB medical plan, select one of the following options:

☐ **OPT-OUT**

Select this option if you and all your eligible dependents have other employer-sponsored group coverage and you will receive a financial incentive from your employer to not enroll in OEBB medical coverage. **By selecting this option, I confirm all eligible dependents have other group coverage.**

You and your eligible dependents MUST have other employer-sponsored group medical coverage to opt-out. Participation or enrollment in the Individual Marketplace Coverage, Oregon Health Plan, Medicaid, Veterans' Administration Benefit Programs, or Student Health Insurance does NOT qualify for OEBB opt-out. **You must provide proof of other group coverage to your employer within five business days or your opt-out will not be effective:**

Carrier	Policy number	Group number
Primary policy holder	Employer	Effective date (*mm/dd/yyyy*)

☐ **Waive**

Select this option if you will not receive a financial incentive from your employer regardless of whether or not you have other medical coverage.

Note: Many employers do not offer a financial incentive, in those cases you should select "Waive."

Vision

Vision plan selection: _____

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

Dental

Dental plan selection: _____

Write in plan selection

Employee signature and authorization

I declare the dependents listed above and I are eligible for the coverages requested per OEBB 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 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 have a QSC; then I am subject to the restrictions of the OEBB QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix 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. 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 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.

Employee signature

Date

Submit this completed form to your employer.

Do not submit this form to OEBB.