



Midyear Change Form

Office use only

Approved by: _____

Approved date: _____

Effective date: _____

Use this form to update your benefits within 31 days of experiencing a Qualified Status Change (QSC) event.

These plan elections or changes will go into effect the first of the month after the event date unless you are requesting coverage that requires carrier approval. Carrier approval coverage will go into effect the first of the month following carrier approval.

You may only make enrollment changes which are consistent with your QSC event. Some events may not allow the change you are requesting. Review the QSC Matrix for more information: <https://www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx>

Employee information

Last name	First name	Middle initial or name		
Employee ID, E number or Social Security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Date of birth (mm/dd/yyyy)		
Home phone number	Work phone number	Cell phone number		
Address	Please, check the box if this is a new address		Apartment or space#	
City	State	ZIP code	County	
Personal email	Work 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 (Select one):	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown
Race (Select at least one. If selecting more than one, circle one as primary):				
<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	

Tobacco usage (Responses in this section are required)

Employee In the last 12 months (Select one):	Spouse/Domestic partner In the last 12 months (Select one):
<input type="checkbox"/> I have used tobacco products <input type="checkbox"/> I have not used tobacco products <input type="checkbox"/> I have never used tobacco products	<input type="checkbox"/> I do not currently have a spouse/domestic partner <input type="checkbox"/> My spouse/domestic partner has used tobacco products <input type="checkbox"/> My spouse/domestic partner has not used tobacco products <input type="checkbox"/> My spouse/domestic partner has never used tobacco products

MSC 6011 (01/2026)

Qualifying Status Change event

Event date: _____

A. Change in employment affecting plan availability or gain/loss of other coverage by			
<input type="checkbox"/> Employee	Spouse/domestic partner		
B. Gain spouse/domestic partner through		Marriage	Domestic partner meets eligibility
C. Loss of spouse/domestic partner by			
	Divorce/Annulment	Termination of Domestic Partnership	Death
D. Gain dependent through			
Marriage/domestic partnership	Birth/adoption/legal custody	Court order	Meeting eligibility
E. Loss of dependent by			
	Divorce/Annulment	Termination of Domestic Partnership	Death
F. Other events			
	Moving out of current plan's service area	Other	

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, OEBC may consider that an intentional misrepresentation of a material fact, for which OEBC 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 OEBC 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 OEBC 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. OEBC's Affidavit of Domestic Partnership can be found online at: <https://www.oregon.gov/oha/OEBC/Pages/Forms.aspx>

Dependent A	<input type="checkbox"/> Enroll	<input type="checkbox"/> Change	<input type="checkbox"/> Remove	Medical	Vision	Dental
Relationship to employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	<input type="checkbox"/> Child			
Gender	Date of birth (mm/dd/yyyy)	Social Security, HICN, or Tax ID number:		Medicare eligible?		
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other				<input type="checkbox"/> Y	<input type="checkbox"/> N	
Last name	First name	Middle				
Address (if different from employee address)		City	State	ZIP		
Ethnicity (Select one):	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown		
Race (Select at least one. If selecting more than one, circle one as primary):						
<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			

Dependent B				<input type="checkbox"/> Enroll	<input type="checkbox"/> Change	<input type="checkbox"/> Remove	<input type="checkbox"/> Medical	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental
Relationship to employee				<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	<input type="checkbox"/> Child			
Gender		Date of birth (mm/dd/yyyy)		Social Security, HICN, or Tax ID number:			Medicare eligible?		
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other							<input type="checkbox"/> Y <input type="checkbox"/> N		
Last name			First name			Middle			
Address (if different from employee address)				City		State		ZIP	
Ethnicity (Select one):				<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown		
Race (Select at least one. If selecting more than one, circle one as primary):									
<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			

Dependent C				<input type="checkbox"/> Enroll	<input type="checkbox"/> Change	<input type="checkbox"/> Remove	<input type="checkbox"/> Medical	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental
Relationship to employee				<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	<input type="checkbox"/> Child			
Gender		Date of birth (mm/dd/yyyy)		Social Security, HICN, or Tax ID number:			Medicare eligible?		
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other							<input type="checkbox"/> Y <input type="checkbox"/> N		
Last name			First name			Middle			
Address (if different from employee address)				City		State		ZIP	
Ethnicity (Select one):				<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown		
Race (Select at least one. If selecting more than one, circle one as primary):									
<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			

Double coverage surcharge info

Are any of your covered family members offered medical insurance as an employee through OEGB or PEBB? Yes No

Are they enrolled in OEGB or PEBB medical insurance offered? (if both answers are yes, a \$5/mo surcharge will be applied) Yes No

Healthcare plan selections

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're choosing not to enroll in an OEGB medical plan, select one of the following options:

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 OEGB medical coverage.

OPT-OUT

- **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, or Student Health Insurance does **NOT** qualify for OEGB 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 don't offer a financial incentive, in those cases you should select “Waive.”

Vision plan selection:

Write in plan selection

(Must be enrolled in Kaiser Medical to enroll in Kaiser Vision)

Dental plan selection:

Write in plan selection

Optional plans (Employee paid voluntary payroll deduction plans)

Plan offering and availability is determined by your employer. Contact your employer for coverage information and to find out which optional plans are available to you.

A. Optional life insurance

For any newly eligible employee, the Optional Employee Life has a guarantee issue* enrollment amount of up to \$200,000 and Optional Spouse/Domestic Partner Life has a guarantee issue* enrollment amount of up to \$30,000 without needing to submit a medical history** to The Standard Insurance Company underwriting for approval.

You can find a link to the Medical History Statement on the OEGB website at:

<https://www.oregon.gov/oha/OEGB/Pages/Forms.aspx>

* Guarantee issue, medical history is not required. If initial request is made with a QSC, guarantee issue amount is applicable.

** You are required to submit a medical history statement on any coverage amount that is not guarantee issue.

Employee optional life insurance

Enroll Change enrollment Decline coverage

Current enrollment* \$ _____ (\$10,000 increments up to \$200,000)

Additional requested amount** \$ _____ (\$10,000 increments up to \$300,000)

Total requested amount \$ _____ (\$500,000 maximum)

Spouse/domestic partner optional life insurance

Enroll Change enrollment Decline coverage

Current enrollment* \$ _____

Additional requested amount** \$ _____ (\$10,000 increments)

Total requested amount \$ _____ (\$500,000 maximum)

Total requested amount must be equal to or less than employee's optional life insurance coverage amount.

Children optional life insurance

Enroll Change enrollment Decline coverage

Total requested amount \$ _____ (\$2,000 increments up to \$10,000 maximum)

B. Optional accidental death & dismemberment (AD&D) insurance

Employee optional AD&D

Enroll Change enrollment Decline coverage

Total requested amount \$ _____ (\$10,000 increments up to \$500,000 maximum)

Medical history is not required

Spouse/Domestic Partner optional AD&D

Enroll Change enrollment Decline coverage

Total requested amount \$ _____ (\$10,000 increments up to \$500,000 maximum)

Medical history is not required. Total requested amount must be equal or less than employee optional AD&D coverage.

Child(ren) optional AD&D

Enroll Change enrollment Decline coverage

Total requested amount \$ _____ (\$2,000 increments up to \$10,000 maximum)

Medical history is not required. You must enroll in employee optional AD&D to enroll your child(ren) in this coverage.

C. Voluntary disability insurance

Monthly premium is calculated on a percentage of your basic monthly salary. A late enrollment penalty will apply if you choose to enroll in coverage at a later date or allow coverage to lapse.

Voluntary short term disability Enroll for coverage Decline coverage

Short term disability plans pay weekly benefits with coverage dates ending after 60 or 90 days depending upon plan enrollment.

Voluntary long term disability Enroll for coverage Decline coverage

Long term disability plans pay monthly benefits with benefits starting after 60 or 90 day waiting periods depending upon plan enrollment.

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

*Affidavit Information: OEGB's Affidavit of Domestic Partnership can be found online at:

<https://www.oregon.gov/oha/OEGB/Pages/Forms.aspx>

Employee signature and authorization

I declare the dependents listed above and I am eligible for the coverages requested per OEGB Administrative Rule (OAR)-Division 10. I have read and understand OAR-Division 10 concerning Definitions and can find this OAR at:

[Division 10](#)

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:

[Division 80](#)

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:

[Division 40](#)

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 have a QSC; then I am subject to the restrictions of the OEGB QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix at:

<https://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. 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 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.

Employee signature

Date

Submit this completed form to your agency payroll or university benefits office.

Do not submit this form to OEGB.