Self-Pay Early Retiree (SPER) Enrollment Form

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

Use this form for your initial transition to Self-Pay Early Retiree (SPER) status.
Update your benefits within 31 days of experiencing one of the status changes listed in Section 1 below.

What type of Early Retiree are you?

- ◯ TYPE A — Active employee becoming SPER (no employer contributions/stipend)
- ◯ TYPE B — Early retiree with employer contribution/stipend ending and becoming SPER (no employer contributions/stipend).

What would you like to do?

- ◯ No changes – keep all current enrollments
- ◯ Change my current medical plan to a lesser plan
- ◯ Cancel one or more OEBB benefit plans*
- ◯ Remove one or more dependents*(Section 4 must be completed)

*** Warning:** If coverage is canceled, it cannot be added back without experiencing a qualifying life event. See the QSC Matrix for details.

SPER information

Last name	First name	Middle
E number or Social Security Number	Gender ◯ M ◯ F ◯ Other	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		

*** 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 or becomes eligible for Medicare. If coverage is canceled for you or a dependent, it cannot be added back at a future date without a qualifying event. See QSC Matrix for details.**

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

Cancel dependent coverage

If you do not wish to cancel any dependent coverage, you may skip this section. Only list dependents if you wish to cancel their coverage. Federal law also requires you to supply the name and address for each spouse/domestic partner or dependent losing coverage so they may be notified of their COBRA rights.

Due to Federal Health Care Reform, OEBB is requesting Ethnicity, Race and Primary Race information for all SPER's and dependents. Please indicate one ethnicity code and at least one race code for each dependent. If indicating more than one race code for a dependent, circle one as primary.

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 make this report on time, the change will be effective the first of the month after your report. If you do not report this change on time, OEBB may consider your omission an intentional misrepresentation of a material fact, for which OEBB may terminate the dependent's coverage effective the first of the month after eligibility was lost.

Attach additional sheets if necessary

Dependent A ◯ Change enrollment ◯ Remove dependent | Remove: ☐ Medical ☐ Vision ☐ Dental

Relationship to SPER: ◯ Spouse ◯ Domestic partner ◯ Child

Gender: ◯ M ◯ F ◯ Other | 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 ◯ Other | 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 ◯ Other	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

Medical, Vision, or Dental Plan Changes

If you do not wish to change any health plan selections, you may skip this section.

Medical

You may not change to a greater plan. You may keep your current plan by leaving this blank or change to a lesser plan.

Change to this lesser medical plan: _____

Vision

You may not change to a different vision plan. You may keep your current plan by leaving this blank or check the box to cancel vision coverage. ☐ Cancel Vision

Dental

You may not change to a different dental plan. You may keep your current plan by leaving this blank or check the box to cancel dental coverage. ☐ Cancel Dental

Cancel optional plans

If you do not wish to change any optional plan selections, you may skip this section.

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

Things to consider:

1. Your previous employer may have automatically enrolled you in a coverage amount for basic life insurance and/or basic AD&D, if applicable.
2. You may not enroll in Optional Plans or change your coverage amounts at this time, you may only cancel coverage. You must be enrolled in Optional Employee Life in order to be enrolled in Optional Spouse/Domestic Partner Optional Life or Child Life.

Employee (SPER) Optional Life Insurance	☐ Cancel Coverage
Spouse/Domestic Partner Optional Life Insurance	☐ Cancel Coverage
Child(ren) Optional Life Insurance	☐ Cancel Coverage
Employee (SPER) Optional AD&D (Accidental Death & Dismemberment)	☐ Cancel Coverage
Spouse/Domestic Partner Optional AD&D	☐ Cancel Coverage
Child(ren) Optional AD&D	☐ Cancel Coverage

Other group coverage

If you are covered by another group medical plan, complete this section and provide proof of other group coverage to OEBB within five business days.

○ I do **not** have other group medical coverage *Skip to next section*	○ I do have other group medical coverage *Complete this section*	
Carrier	Policy number	Group number
Primary Policy Holder	Employer	Effective Date (mm/dd/yyyy)

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 ○ OR ○	Whole%
Name		Address			
City	State	ZIP	Relationship	Primary or Contingent ○ OR ○	Whole%
Name		Address			
City	State	ZIP	Relationship	Primary or Contingent ○ OR ○	Whole%
Name		Address			
City	State	ZIP	Relationship	Primary or Contingent ○ OR ○	Whole%

*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 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 QSC's. 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 your completed form to:

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

By fax: 503-378-5832