Self-Pay Early Retiree (SPER) 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: http://www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx

SPER information

Last name | First name | M.I.

Social Security Number, or E 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

*** 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.

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

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

In this section, OEBB is collecting tobacco usage information for you and your spouse/domestic partner (if applicable). This information will be used to determine your premium amount(s) for Optional Member and Optional Spouse/Domestic Partner Life plans through The Standard. **You must complete this section even if you do not enroll in these plans.**

Employee	**Spouse/Domestic partner**
In the last 12 months *(Select one)*:	In the last 12 months *(Select one)*:
☐ I have used tobacco products	☐ I do not currently have a spouse/domestic partner
☐ I have ***not*** used tobacco products	☐ My spouse/domestic partner has used tobacco products
☐ I have never used tobacco products	☐ My spouse/domestic partner has ***not*** used tobacco products
	☐ My spouse/domestic partner has never used tobacco products

Qualifying status change event

Event date: _____

A. Change in employment affecting plan availability or gain/loss of other coverage by

☐ 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 *(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 member's 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 employing entity — 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 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

◯ Enroll ◯ Change ◯ Remove ☐ 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 | M.I.

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 ◯ Change ◯ Remove ☐ 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 | M.I.

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

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Dependent C ◯ Enroll ◯ Change ◯ Remove ☐ 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 | M.I.

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):*

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☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent D ◯ Enroll ◯ Change ◯ Remove ☐ 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 | M.I.

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 E ◯ Enroll ◯ Change ◯ Remove ☐ 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 | M.I.

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):*

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☐ White ☐ Other ☐ Refused ☐ Unknown

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Healthcare plan selections

Medical

Medical plan selection: _____ ☐ Decline Medical

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

Vision

☐ Decline Vision

Vision plan selection: _____

Write in plan selection. Must be enrolled in Kaiser Medical to enroll in Kaiser Vision.

Dental

☐ Decline Dental

Dental plan selection: _____

Write in plan selection.

Optional plans *(Employee paid voluntary payroll deduction plans)*

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.

A. Optional life insurance

Employee (SPER) optional life insurance ◯ Decrease enrollment ◯ Cancel coverage

Decrease my current enrollment amount to* $ _____ ($10,000 increments up to $100,000)

Spouse/domestic partner optional life insurance ◯ Decrease enrollment ◯ Cancel coverage

Decrease my current enrollment amount to* $ _____

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

Child(ren) optional life insurance ◯ Decrease enrollment ◯ Cancel coverage

Decrease my current enrollment amount to* $ _____ ($2,000 increments up to $10,000 maximum)

Medical history is not required, you must enroll in member optional life to enroll your child(ren) in this coverage.

Declining coverage ends eligibility

I understand that if I decline Medical, Dental and/or Vision coverage, I lose eligibility for that type of coverage and will not be allowed to re-enroll in that type of coverage in the future, regardless of any life events that may occur.

_____ _____

Employee signature Date

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

Employee optional AD&D ◯ Decrease enrollment ◯ Cancel coverage

Decrease my current enrollment amount to* $ _____ ($10,000 increments up to $500,000 maximum)

Medical history is not required

Spouse/domestic partner optional AD&D ◯ Decrease enrollment ◯ Cancel coverage

Decrease my current enrollment amount to* $ _____ ($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 ◯ Decrease enrollment ◯ Cancel coverage

Decrease my current enrollment amount to* $ _____ ($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.

* You are required to submit a medical history statement on any coverage amount that is not guarantee issue or if you are requesting a change in enrollment coverage.

C. Voluntary long term care insurance

Member Long Term Care enrollment as a newly eligible member has guarantee issue amounts of up to $6,000 in monthly benefit, professional home care option for 3 or 6 year duration without having to submit medical history for enrollment approval. Enrollment requests for unlimited duration, amount over $6,000, total home care, and 5% simple inflation options, enrollment after first eligible or a future date, and Spouse/Domestic Partner Long Term Care *will require the UNUM medical history statement to be filled out and submitted to UNUM.*

You can find a link to UNUM forms on the OEBB website:
http://www.oregon.gov/oha/OEBB/Pages/Forms.aspx

Employee (SPER) long term care*

☐ Decrease coverage ☐ Decline coverage

Plan option	Coverage amount	Duration
☐ Professional Home Care ☐ Professional Home Care – 5% inflation ☐ Total Home Care ☐ Total Home Care – 5% inflation	☐ $2,000 ☐ $5,000 ☐ $8,000 ☐ $3,000 ☐ $6,000 ☐ $9,000 ☐ $4,000 ☐ $7,000	☐ 3 Years ☐ 6 Years ☐ Unlimited

Spouse/domestic partner long term care*

☐ Decrease coverage ☐ Decline coverage

Plan option	Coverage amount	Duration
☐ Professional Home Care ☐ Professional Home Care – 5% inflation ☐ Total Home Care ☐ Total Home Care – 5% inflation	☐ $2,000 ☐ $5,000 ☐ $8,000 ☐ $3,000 ☐ $6,000 ☐ $9,000 ☐ $4,000 ☐ $7,000	☐ 3 Years ☐ 6 Years ☐ Unlimited

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 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 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:

Division 40

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. 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.

SPER Signature _____ Date _____

Submit to form to:	
email: OEBB.Benefits@odhsoha.oregon.gov **by fax:** (503) 378-5832	**or by mail:** OEBB Member Services 500 Summer Street NE, E-88 Salem, OR 97301-1063