2022–23 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, 2021. 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 ◯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. Notify OEBB 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.**

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)*

Member	**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

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 ◯ 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 information *(Attach additional sheets if necessary)*

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

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 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

Vision plan selection: _____ ☐ Decline Vision

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

Dental

Dental 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 ◯ Continue enrollment ◯ Decline coverage

Decrease enrollment to $_____ ($10,000 increments)

Spouse/Domestic Partner Optional Life Insurance ◯ Continue enrollment ◯ 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 ◯ Continue enrollment ◯ 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 ◯ Continue enrollment ◯ Decline coverage

Decrease enrollment to $_____ ($10,000 increments)

Spouse/Domestic Partner Optional AD&D Insurance ◯ Continue enrollment ◯ 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 ◯ Continue enrollment ◯ 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 ◯ 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'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 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 QSCs. 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 re-qualify) 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 this form to OEBB by September 15.

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