



2020–21 Plan Year

HB 2557 Member Enrollment Form

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

Member information

Last name	First name	Middle
E number or Social Security Number	Gender M F Other	Date of birth (<i>mm/dd/yyyy</i>)
Home phone number	Work phone number	Cell phone number
May OEGB send text messages to this number? Standard text message and data rates apply.	Yes	No
Personal email	Work email	
Address	Check if new address	Apartment or space#
City	State	ZIP
Are you Medicare eligible?	Yes	No
Are you serving or did you ever serve in the military?	Yes	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?		
Ethnicity (<i>Select one</i>):	Hispanic	Non-Hispanic/Non-Latino
		Refused
Race (<i>Select at least one. If selecting more than one, circle one as primary</i>):		
Asian	Black/African American	American Indian/Alaska Native
White	Other	Refused
		Native Hawaiian/Other Pacific Islander
		Unknown

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

<p>Member In the last 12 months (<i>Select one</i>):</p> <p style="padding-left: 20px;">I have used tobacco products</p> <p style="padding-left: 20px;">I have not used tobacco products</p> <p style="padding-left: 20px;">~ I have never used tobacco products</p>	<p>Spouse/Domestic partner In the last 12 months (<i>Select one</i>):</p> <p style="padding-left: 20px;">I do not currently have a spouse/domestic partner</p> <p style="padding-left: 20px;">My spouse/domestic partner has used tobacco products</p> <p style="padding-left: 20px;">My spouse/domestic partner has not used tobacco products</p> <p style="padding-left: 20px;">~ My spouse/domestic partner has never used tobacco products</p>
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Dependent information *(Attach additional sheets if necessary)*

You must report to OEGB's HB 2557 Coordinator 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, OEGB may consider that an intentional misrepresentation of a material fact, for which OEGB 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 OEGB Affidavit of Domestic Partnership*

By Registered Certificate *(Copy not required)*

* Affidavit Information: If you are adding a domestic partner by OEGB Affidavit, you must submit the affidavit to OEGB within five business days of this enrollment or the individual's coverage will not be effective. OEGB's Affidavit of Domestic Partnership can be found online at: <http://www.oregon.gov/oha/OEGB/pages/Forms.aspx>.

Dependent A				Enroll: Medical
Relationship to member:		Spouse	Domestic partner	Child
Gender:		Date of birth: <i>(mm/dd/yyyy)</i>	Social Security, HICN, or Tax ID Number:	Medicare eligible?*
M	F	Other		~ Yes No
Last name:		First name:	Middle:	
Address <i>(if different from member address)</i> :			City:	State: ZIP:
Ethnicity <i>(Select one):</i>		Hispanic	~ Non-Hispanic/Non-Latino	Refused Unknown
Race <i>(Select at least one. If selecting more than one, use secondary drop down):</i>				
Asian	Black/African American	American Indian/Alaska Native	Native Hawaiian/Other Pacific Islander	
White	Other	Refused	Unknown	

Dependent B				Enroll: Medical
Relationship to member:		Spouse	Domestic partner	Child
Gender:		Date of birth: <i>(mm/dd/yyyy)</i>	Social Security, HICN, or Tax ID Number:	Medicare eligible?*
M	F	Other		Yes No
Last name:		First name:	Middle:	
Address <i>(if different from member address)</i> :			City:	State: ZIP:
Ethnicity <i>(Select one):</i>		Hispanic	Non-Hispanic/Non-Latino	Refused Unknown
Race <i>(Select at least one. If selecting more than one, circle one as primary):</i>				
Asian	Black/African American	American Indian/Alaska Native	Native Hawaiian/Other Pacific Islander	
White	Other	Refused	Unknown	

Medical plan selection

Check the box for the plan you are selecting to enroll in.



Moda Medical Plan	Kaiser Medical Plan
<input type="checkbox"/> 3*	<input type="checkbox"/> 3
<input type="checkbox"/> 5*	
<input type="checkbox"/> 7*	

*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>

Member signature and authorization

I declare the dependents listed above and I am eligible for the coverages requested per OEBA 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 OEBA’s HB 2557 Coordinator 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 OEBA’s eligibility requirements, or until I elect to change them subject to the provisions of OEBA’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 OEBA QSCs. I have reviewed and understand the Qualified Status Change (QSC) Matrix which can be found at:

<http://www.oregon.gov/oha/OEBA/Pages/QSC-Matrix.aspx>

I have read the benefit materials and I understand the limitations and qualifications of the OEGB 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 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.

Member signature

Date

Submit your completed form to:

By Mail: OEGB, HB 2557 Enrollment
500 Summer Street NE, E-88
Salem, OR 97301-1063

Phone: 1-888-469-6322 **Fax:**
503-378-5832
OEGB.Benefits@dhsosha.state.or.us