

# 2014-15 Plan Year HB 2557 Member Enrollment Form

Entity Use Only	
Approved by	_____
Date Approved	_____
Effective Date	_____

## 1. Member Information

				Member ID, SSN, or E Number	
Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			Medicare Eligible? <input type="checkbox"/> YES SSN/HICN _____ <input type="checkbox"/> NO		
Race (If more than one race selected please 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			
Contact Address	<input type="checkbox"/> Check if New Address	Apt or Space #	City	State	Zip
Work Email			Personal Email		
Work Phone			Home Phone		

## 2. Tobacco Usage (Responses in this section are required regardless of enrollments)

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 Employee and Optional Spouse/Domestic Partner Life plans through The Standard beginning October 1, 2014. You must complete this section even if you do not enroll in these plans.

<p><b>Please select one of the following:</b></p> <input type="checkbox"/> I have used tobacco products in the last 12 months <input type="checkbox"/> I haven't used tobacco products in the last 12 months <input type="checkbox"/> I have never used tobacco products	<p><b>Please select one of the following:</b></p> <input type="checkbox"/> I do not currently have a spouse or domestic partner <input type="checkbox"/> My spouse/domestic partner has used tobacco products in the last 12 months <input type="checkbox"/> My spouse/domestic partner hasn't used tobacco products in the last 12 months <input type="checkbox"/> My spouse/domestic partner has never used tobacco products
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## 3. Healthy Futures Participation (Incentivized Deductible or Copay Program)

### A. 2013-14 Participation - Healthy Actions Reporting

I and my Spouse/Domestic Partner (if applicable) have completed the Health Assessment by May 31, 2014 and have completed the two Healthy Actions reported below by August 15, 2014:

Member		Spouse/Domestic Partner	
<input type="checkbox"/> I do not have a Spouse/Domestic Partner enrolled in medical coverage		<input type="checkbox"/> I have a Spouse/Domestic Partner enrolled in medical coverage	
<input type="checkbox"/> Healthy Team Healthy U (counts as two actions)		<input type="checkbox"/> Healthy Team Healthy U (counts as two actions)	
<input type="checkbox"/> Weight Watchers	<input type="checkbox"/> Tobacco Cessation	<input type="checkbox"/> Weight Watchers	<input type="checkbox"/> Tobacco Cessation
<input type="checkbox"/> Mood Helper	<input type="checkbox"/> (Write-In Other Action)	<input type="checkbox"/> Mood Helper	<input type="checkbox"/> (Write-In Other Action)
<input type="checkbox"/> I did not complete actions	<input type="checkbox"/> (Write-In Other Action)	<input type="checkbox"/> I did not complete actions	<input type="checkbox"/> (Write-In Other Action)

## B. 2014-15 Participation – Agreement to Participate

1. I understand that I and my spouse or domestic partner (if applicable) have until March 31, 2015 to make a decision about participating in Healthy Futures and we can either enter the MyOEBB Member Module or contact our educational entity until the above date to agree to participate in Healthy Futures.
2. I understand that if I agree to participate in Healthy Futures I will need to complete the Health Assessment for my medical plan, either Kaiser or Moda Health, and I will complete the Health Assessment by May 31, 2015.
3. I understand that if I agree to participate in Healthy Futures I will need to complete two healthy actions by August 15, 2015.
4. I understand that if my spouse or domestic partner (if applicable) agrees to participate in Healthy Futures they will independently have to complete the Health Assessment for their medical plan, either Kaiser or Moda Health, by May 31, 2015.
5. I understand that if my spouse or domestic partner (if applicable) agrees to participate in Healthy Futures they will independently need to complete two healthy actions by August 15, 2015.
6. I and my spouse or domestic partner (if applicable) will complete two healthy actions before August 15, 2015, as follows:
  - a. If my/their health assessment indicates that my/their weight is a risk to my/their health, or if my/their BMI exceeds 27 or my/their waist circumference exceeds a certain number of inches (35 inches for women unless pregnant or within 24 months after giving birth, or 40 inches for men), one of my/their healthy actions will address that risk. Some examples of healthy actions to address this risk are:
    - participate in Weight Watchers
    - nutritional counseling by a registered dietician
    - a program of physical activity
    - an assessment and action plan developed by my health care provider
    - participation in Healthy TEAM Healthy U, a team-based health engagement program sponsored by OEBB
  - b. If my/their health assessment indicates that tobacco use is a risk to my/their health, one of my/their healthy actions will address that risk. Some examples of healthy actions to address this risk are:
    - participate in a tobacco cessation program - either Quit for Life? or another therapy recommended by my healthcare provider
    - work through the e-tools on your medical carrier's website on tobacco cessation
    - participation in Healthy TEAM Healthy U, a team-based health engagement program sponsored by OEBB
  - c. If weight or tobacco are not health risks for me (or my spouse/domestic partner), I/they will take action to address other health risks identified in my assessment, or to maintain my current good health. Some examples include:
    - other online programs available through the carriers, like "Fire Up Your Feet" or "Moodhelper" through Kaiser, or "Fit It In" through Moda Health/ODS
    - participate in a school employee wellness activity or a team-based/worksites-based health promotion program
    - participate in walking programs sponsored by associations or clubs, PTA, health clubs
    - e-lessons on topics of your choice (available on your medical carrier's website)
    - preventive services recommended for your age by the U.S. Preventive Services Taskforce (annual dental cleaning, mammogram, colonoscopy, etc.)
    - participation in Healthy TEAM Healthy U, a team-based health engagement program sponsored by OEBB
7. I understand that the actions listed above are just examples. There are many actions that support good health which will qualify.
8. I understand that if a licensed medical professional from Kaiser or Moda Health calls me about a diagnosed chronic condition or other illness based on information submitted by my healthcare provider, I will accept or return the call to learn about potential support services for managing my condition.
9. I understand that if a licensed medical professional from Kaiser or Moda Health calls my spouse or domestic partner, if applicable, about a diagnosed chronic condition or other illness based on information submitted by his or her healthcare provider, he or she will accept or return the call to learn about potential support services for managing their condition.
10. I will document the actions I take for Healthy Futures. My documentation will include dates of completing the Health Assessment and healthy actions, contacts with a case or disease manager and participation in program requirements, if applicable, for weight management or tobacco cessation.
11. My spouse or domestic partner (if applicable) will document the actions he or she takes for Healthy Futures. Their documentation will include dates of completing the Health Assessment and healthy actions, contacts with a case or disease manager and participation in program requirements, if applicable, for weight management or tobacco cessation.
12. I have informed my spouse or domestic partner that he or she must individually complete a Health Assessment by May 31, 2015, and two healthy actions by August 15, 2015.
13. I understand that I, and my spouse or domestic partner (if applicable), can request to have answers from my and my spouse or domestic partner's (if applicable) Health Assessment shared with my/their primary care provider with my/their approval.
14. I understand that if a medical condition or disability makes it unreasonably difficult for me or my spouse or domestic partner (if applicable) to achieve a standard described in 1 through 6 (above), or if attempting to do so is medically inadvisable, a reasonable alternative to the standard will be provided. I further understand that I may contact OEBB at 888-469-6322, and OEBB will work with me (and, if I wish, with my doctor) to find a reasonable alternative that is right for me in light of my health status.

**NOTE: If you have a spouse or domestic partner covered on your OEBB medical plan, you both need to complete the requirements of the Healthy Futures program in order to receive the incentivized medical deductible or copay plan for the 2015-16 Plan Year. If one of you completes the requirements, but the other does not, no incentive will be received.**

The requirements of the Healthy Futures program are:

- 1) agree to participate in Healthy Futures by March 31, 2015;
- 2) complete the online health assessment provided by your medical carrier by May 31, 2015;
- 3) complete two healthy actions by August 15, 2015; and
- 4) report your healthy actions during the 2015 Open Enrollment period.

**YES** – I/We agree to participate in the Healthy Futures program.

**NO** – I/We do not agree to participate in the Healthy Futures program.

## 4. 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 (no copy required)**

**Affidavit Information** – If you are adding a domestic partner by 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: [www.oregon.gov/oha/OEBB/docs/Form/DPAffidavit.pdf](http://www.oregon.gov/oha/OEBB/docs/Form/DPAffidavit.pdf)

### Dependent A

**Relationship Codes** ("Rel Code" below): **SP**=Spouse, **CH**=Member and/or Spouse's child, **DD**=Disabled Dependent, **DP**=Domestic Partner, **DP CH**=Domestic Partner's Child

Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Rel Code	Gender M F <input type="checkbox"/> <input type="checkbox"/>	Enroll Med Vis Den <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			Medicare Eligible? <input type="checkbox"/> YES SSN/HICN _____ <input type="checkbox"/> NO			
Race (select one or more, 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			
Address (if different from employee address)		Apt #	City	State	Zip	

### Dependent B

**Relationship Codes** ("Rel Code" below): **SP**=Spouse, **CH**=Member and/or Spouse's child, **DD**=Disabled Dependent, **DP**=Domestic Partner, **DP CH**=Domestic Partner's Child

Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Rel Code	Gender M F <input type="checkbox"/> <input type="checkbox"/>	Enroll Med Vis Den <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			Medicare Eligible? <input type="checkbox"/> YES SSN/HICN _____ <input type="checkbox"/> NO			
Race (select one or more, 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			
Address (if different from employee address)		Apt #	City	State	Zip	

### Dependent C

**Relationship Codes** ("Rel Code" below): **SP**=Spouse, **CH**=Member and/or Spouse's child, **DD**=Disabled Dependent, **DP**=Domestic Partner, **DP CH**=Domestic Partner's Child

Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Rel Code	Gender M F <input type="checkbox"/> <input type="checkbox"/>	Enroll Med Vis Den <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			Medicare Eligible? <input type="checkbox"/> YES SSN/HICN _____ <input type="checkbox"/> NO			
Race (select one or more, 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			
Address (if different from employee address)		Apt #	City	State	Zip	

## 5. Medical Plan Selection

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Moda Medical Plan E - Statewide  | <input type="checkbox"/> Moda Medical Plan E - Synergy  | <input type="checkbox"/> Moda Medical Plan E - Summit  |
| <input type="checkbox"/> Moda Medical Plan G - Statewide  | <input type="checkbox"/> Moda Medical Plan G - Synergy  | <input type="checkbox"/> Moda Medical Plan G - Summit  |
| <input type="checkbox"/> *Moda Medical Plan H - Statewide | <input type="checkbox"/> *Moda Medical Plan H - Synergy | <input type="checkbox"/> *Moda Medical Plan H - Summit |
- \*To enroll in Moda Medical Plan H you must be qualified for and contributing to a Health Savings Account (HSA)*
- Kaiser Permanente Medical Plan 3

If selecting a Moda Medical **Synergy** or **Summit** Plan, Please list the Medical Home choice for each covered member. A list of Medical Home Providers can be found at: <https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml>

Member: \_\_\_\_\_ Medical Home: \_\_\_\_\_

Dependent A: \_\_\_\_\_ Medical Home: \_\_\_\_\_

Dependent B: \_\_\_\_\_ Medical Home: \_\_\_\_\_

Dependent C: \_\_\_\_\_ Medical Home: \_\_\_\_\_

**Please attach sheet for additional Dependents and their Medical Home selections if needed**

## 6. Member Signature and Authorization

I declare the dependents listed above and I are eligible for the coverages requested per OEBC Administrative Rule (OAR)-Division 10. 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](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](http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_080.html)

I understand I have 31 days to notify OEBC 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](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 OEBC's eligibility requirements, or until I elect to change them subject to the provisions of OEBC'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 OEBC QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix at

<http://www.oregon.gov/OHA/OEBC/docs/QSCMatrix.pdf>

I have read the benefit materials and I understand the limitations and qualifications of the OEBC 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 OEBC 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 OEBC 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 OEBC:**

**1225 Ferry St SE, Suite B  
Salem, OR 97301-4278**

**Phone: 1-888-469-6322**

**Fax: 503-378-5832**