2017-18 Plan Year Midyear Change Form

Employer Use Only	
Approved by	
Date Approved	
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

1. Employee Information

Last Name	First Name	MI

Employee ID, Social Security Number, or E Number	Gender ☐ Male ☐ Female	Date of Birth (mm-dd-yyyy)

Home Phone	Work Phone	Cell Phone

Personal Email	Work Email

Address	Apt or Space #

City	State	Zip	County

Medicare Eligible? ☐ Yes ☐ No

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

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

3. 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/Termination of Domestic Partnership ☐ Ceasing to meet eligibility ☐ Death

F. Other events ☐ Moving out of current plan's service area ☐ Other

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4. Dependent Information (Attach additional sheets if necessary)

You must report to your employer's benefits administrator 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)

* Domestic partner eligibility rules may vary by employer – 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 your employer 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:	Child of:	Overage Disabled Dependent of:
☐ Spouse ☐ Domestic Partner	☐ Employee/Spouse ☐ Domestic Partner	☐ Employee/Spouse ☐ Domestic Partner

Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy)	Social Security, HICN, or Tax ID Number:	Medicare Eligible? ☐ Y ☐ N

Last Name	First Name	MI

Address (if different from Employee 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 ☐ American Indian/Alaska Native ☐ Black/African American ☐ Refused
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown

DEPENDENT B ☐ Enroll ☐ Change ☐ Remove ☐ Medical ☐ Vision ☐ Dental

Relationship to Employee:	Child of:	Overage Disabled Dependent of:
☐ Spouse ☐ Domestic Partner	☐ Employee/Spouse ☐ Domestic Partner	☐ Employee/Spouse ☐ Domestic Partner

Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy)	Social Security, HICN, or Tax ID Number:	Medicare Eligible? ☐ Y ☐ N

Last Name	First Name	MI

Address (if different from Employee 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 ☐ American Indian/Alaska Native ☐ Black/African American ☐ Refused
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown

DEPENDENT C ☐ Enroll ☐ Change ☐ Remove ☐ Medical ☐ Vision ☐ Dental

Relationship to Employee:	Child of:	Overage Disabled Dependent of:
☐ Spouse ☐ Domestic Partner	☐ Employee/Spouse ☐ Domestic Partner	☐ Employee/Spouse ☐ Domestic Partner

Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy)	Social Security, HICN, or Tax ID Number:	Medicare Eligible? ☐ Y ☐ N

Last Name	First Name	MI

Address (if different from Employee 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 ☐ American Indian/Alaska Native ☐ Black/African American ☐ Refused
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown

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5. Healthcare Plan Selections

MEDICAL

Medical Plan Selection: _____

Write in plan selection.

If selecting a Moda Medical CCM Synergy/CCM Summit Plan, prior to the coverage start date you must contact Moda Health to select a Medical Home Provider for each covered employee. A list of Medical Home Providers can be found at: https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml

If you are choosing to *not* enroll in an OEBB medical plan, select one of the following options:

☐ **OPT-OUT** Select this option if you and all your eligible dependents have other employer-sponsored group coverage and you will receive a financial incentive from your employer to not enroll in OEBB medical coverage.
By selecting this option, I confirm all eligible dependents have other group coverage.

You and your eligible dependents MUST have other employer-sponsored group medical coverage to opt-out. Participation or enrollment in the Individual Marketplace Coverage, Oregon Health Plan, Medicaid, Veterans' Administration Benefit Programs, or Student Health Insurance does NOT qualify for OEBB opt-out.

You must provide proof of other group coverage to your employer within five business days or your opt-out will not be effective:

Carrier	Policy Number	Group Number

Primary Policy Holder	Employer	Effective Date (mm/dd/yyyy)

☐ **WAIVE** Select this option if you will ***not*** receive a financial incentive from your employer regardless of whether or not you have other medical coverage.

Note: Many employers do not offer a financial incentive, in those cases you should select "Waive."

VISION

Vision Plan Selection: _____ ☐ Decline Vision

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

DENTAL

Dental Plan Selection: _____ ☐ Decline Dental

Write in plan selection.

DENTAL LATE ENROLLMENT PENALTY

I understand **if I decline dental coverage** when initially eligible or allow coverage to lapse, then choose to enroll at a future Open Enrollment period, any enrolled dependents and I will be subject to a 12-month waiting period, meaning only diagnostic and preventive care (cleanings, x-rays, and exams) will be covered for the first 12 months of dental coverage.

_____ _____

Employee Signature Date

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6. Optional Plans (Employee paid voluntary payroll deduction plans.)

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

A. Optional Life Insurance

As a newly eligible employee for your first time enrollment, the Optional Employee Life has a guarantee issue* enrollment amount of up to $100,000 and Optional Spouse/Domestic Partner Life has a guarantee issue* enrollment amount of up to $30,000 without needing to submit a medical history** to The Standard Insurance Company underwriting for approval.

You can find a link to the Medical History Statement on the OEBB website at:
http://www.oregon.gov/oha/OEBB/Pages/Forms.aspx

* Guarantee issue, medical history is not required. If initial request is made with a QSC, guarantee issue amount is applicable.
** You are required to submit a medical history statement on any coverage amount that is not guarantee issue.

Employee Optional Life Insurance ☐ Enroll ☐ Change Enrollment ☐ Decline Coverage

Current Enrollment* $ _____ ($10,000 increments up to $100,000)

Additional Requested Amount** $ _____ ($10,000 increments up to $400,000)

Total Requested Amount $ _____ ($500,000 maximum)

Spouse/Domestic Partner Optional Life Insurance ☐ Enroll ☐ Change Enrollment ☐ Decline Coverage

Current Enrollment* $ _____

Additional Requested Amount** $ _____ ($10,000 increments)

Total Requested Amount $ _____ ($500,000 maximum)

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

Child(ren) Optional Life Insurance ☐ Enroll ☐ Change Enrollment ☐ Decline Coverage

Total Requested Amount $ _____ ($2,000 increments up to $10,000 maximum)

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

B. Optional Accidental Death & Dismemberment (AD&D) Insurance

Employee Optional AD&D ☐ Enroll ☐ Change Enrollment ☐ Decline Coverage

Total Requested Amount $ _____ ($10,000 increments up to $500,000 maximum)

Medical history is not required.

Spouse/Domestic Partner Optional AD&D ☐ Enroll ☐ Change Enrollment ☐ Decline Coverage

Total Requested Amount $ _____ ($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 ☐ Enroll ☐ Change Enrollment ☐ Decline Coverage

Total Requested Amount $ _____ ($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.

C. Voluntary Disability Insurance

Monthly premium is calculated on a percentage of your basic monthly salary. *A late enrollment penalty will apply if you choose to enroll in coverage at a later date or allow coverage to lapse.*

Voluntary Short Term Disability ☐ Enroll For Coverage ☐ Decline Coverage

Short Term Disability plans pay weekly benefits with coverage dates ending after 60 or 90 days depending upon plan enrollment.

Voluntary Long Term Disability ☐ Enroll For Coverage ☐ Decline Coverage

Long Term Disability plans pay monthly benefits with benefits starting after 60 or 90 day waiting periods depending upon plan enrollment.

D. Voluntary Long Term Care Insurance

Employee Long Term Care enrollment as a newly eligible employee 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

* 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.

Employee Long Term Care*

☐ Request Coverage ☐ Change Coverage ☐ Decline Coverage

Plan Option		Coverage Amount			Duration
☐ Professional Home Care	☐ Professional Home Care – 5% Inflation	☐ $2,000	☐ $5,000	☐ $8,000	☐ 3 Years
☐ Total Home Care	☐ Total Home Care	☐ $3,000	☐ $6,000	☐ $9,000	☐ 6 Years
		☐ $4,000	☐ $7,000		☐ Unlimited

Spouse/Domestic Partner Long Term Care*

☐ Request Coverage ☐ Change Coverage ☐ Decline Coverage

Plan Option		Coverage Amount			Duration
☐ Professional Home Care	☐ Professional Home Care – 5% Inflation	☐ $2,000	☐ $5,000	☐ $8,000	☐ 3 Years
☐ Total Home Care	☐ Total Home Care	☐ $3,000	☐ $6,000	☐ $9,000	☐ 6 Years
		☐ $4,000	☐ $7,000		☐ Unlimited

6. 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

7. Employee 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

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 my employer 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 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. 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 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.

Employee Signature _____ Date _____

Submit the completed form to your employer.

Do not submit this form to OEBB.