

Life Insurance Beneficiary Designation Only

EMPLOYEE INFORMATION

School District Name: _____ Employee ID, SSN, E #: _____
 Employee Name: First _____ Middle _____ Last _____
 Employee Date of Birth: _____ Male Female Phone: (H) _____ (W) _____
 Employee Address: _____
 _____ City _____ State _____ Zip _____
 Mailing Address: (if different from above) _____ E-mail _____
 Dependent Address: (if different from above) _____

Employee Classification:	<input type="checkbox"/> Admin/Conf	<input type="checkbox"/> Licensed	<input type="checkbox"/> Classified	<input type="checkbox"/> Superintendent
Employee Status:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Retired	

BENEFICIARY DESIGNATION

Select one:

- I elect the standard designation with no beneficiaries listed. (Creates a chain of beneficiaries that automatically allows for future marriages, divorces, births, deaths or adoptions within your family as established by Oregon law.)
- I designate the following beneficiary (ies). Attach additional sheets if necessary.

Name of Beneficiary or Trust	DOB	Relationship	Primary or Contingent	Percentage
			<input type="checkbox"/> <input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	

EMPLOYEE SIGNATURE AND AUTHORIZATION

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the elections I made are in effect, pending approval by The Standard Insurance Company (if required), as long as I continue to meet my Educational Entity's eligibility requirements or until I elect to change them subject to the terms of OEBB's plan eligibility requirements or until I elect to change them subject to the terms of OEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the OEBB life and disability benefits program. If applicable, I authorize my Educational Entity to deduct in advance each month from any earned or accrued wages due to me, such amount deduct in advance each month from any earned or accrued wages due to me, such amount as is necessary to pay the premium rates for the coverage I elected.

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 or enrollment, denial of future enrollment, or civil damages.

This form supersedes all forms 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

"Educational Entity Use Only"

Approved by (initials): _____
 Date: _____

Approved change effective date: _____
 MyOEBB updated by (initials): _____