# Medical, Dental, and Vision Enrollment and Change Form

## Active Employee and Retiree Plan Year 2009

- **New Hire**
- **Change**
- **Open Enrollment**

### SECTION A - EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>School District Name</td>
<td>Eugene School District 4J</td>
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<tr>
<td>Employee Name: First</td>
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<td>Middle</td>
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<td>Last</td>
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<tr>
<td>Employee Date of Birth</td>
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<td>Male □ Female □ Phone: (H)</td>
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<tr>
<td>Employee Address:</td>
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<td>City</td>
<td>State</td>
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<td>E-mail</td>
<td>Zip</td>
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<tr>
<td>Dependent Address:</td>
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### Employee Classification:

- Admin/Conf
- Licensed
- Part Time
- Retired

### Qualified Status Change:

- New Hire
- Divorce
- Birth/Adoption
- Meets Domestic Partner eligibility
- Marriage
- Dependent ceases to meet eligibility
- Death of spouse/dependent
- Qualified Medical Child Support Order
- Employment status change which affects eligibility

### SECTION B - MEDICAL, DENTAL, AND VISION PLAN ELECTIONS

- **Medical Benefit Plan Selection**
  - PLAN 3 □ PLAN 5 □ PLAN 7 □ PLAN 8
  (must elect a medical plan above to also elect dental)

- **Dental Benefit Plan Selection**
  - YES (I have elected a dental plan above) □ NO

- **Vision Benefit Plan Selection**
  (vision tied to all medical plans, except licensed subs)

### ALTERNATIVE CHOICE:

- **MEDICAL OPT OUT**
  You must have other group coverage to be eligible.

### SECTION C - DEPENDENT INFORMATION AND PLAN SELECTION

For new enrollment, indicate all eligible dependents you wish to cover and check the plan offerings in which you will enroll your dependents. For changes, indicate whether you are adding or dropping the dependent(s) and list their information.

Relationship Key:  
- SP = Spouse
- DPA = Domestic Partner by Affidavit
- DPC = Domestic Partner by Certificate
- CH = Employee and/or Spouse's child
- DPCH = Domestic Partner's child
- AFFCH = Child by Affidavit
- DD = Disabled Dependent

### Add / Drop + / -

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Birth Date (MM-DD-YY)</th>
<th>Relationship</th>
<th>Gender</th>
<th>Plan</th>
<th>Den</th>
<th>Vision</th>
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rev 07/09
C.1 Dependent certification  Detailed eligibility information is available at:
www.oregon.gov/DAS/OEBB

☐ I certify that all my dependent child(ren) between the ages of 19 and up to age 26 meet
the eligibility requirements for enrollment in the OEBB plans. Please consult your district
regarding restrictions for eligibility of overage dependents.

C.2 Domestic Partner - Check the appropriate box.
☐ Domestic Partner by OEBB Affidavit of Domestic Partnership (attach Affidavit to this form)
☐ Domestic Partner by Certificate of Registered Domestic Partnership

Please consult your district regarding restrictions for eligibility of opposite sex Domestic Partners.

SECTION D - OTHER GROUP COVERAGE INFORMATION

Are you or any of your dependents covered through another OEBB or group plan? Yes ☐  No ☐
If yes, please complete the following information:
Check which plan:  ☐ Medical

Carrier

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Group Number</th>
<th>Effective Date</th>
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</table>

Subscriber's Name

Employer

SECTION E - MEDICARE INFORMATION (only complete if Medicare eligible)

☐ I am covered by Medicare  ☐ My dependent(s) is covered by Medicare*

* In order to maintain benefits for your Medicare eligible dependent, please provide to your employer one of the following:
Social Security Number (SSN) ________________ Medicare Claim Number (HICN) ________________
☐ Refusal to Provide Requested Information

SECTION F - 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 benefit elections made on this application 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 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.

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 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 __________________________

If you are an active employee or retiree: Upon completion, please return this form to your Educational Entity
Benefits/Payroll office. Do not mail this form to OEBB. If mailed to OEBB, it will be returned to your Educational
Entity and could cause a delay in benefits.

If you are benefits eligible due to HB 2557 and enrolling in benefits or making a change, please mail this completed
form to:  OEBB, 1225 Ferry Street SE, Salem, OR 97301
**Life and Disability Enrollment and Change Form**  
**Active Employee and Retiree Plan Year 2009**

- **Qualified Status Change**  
- **Open Enrollment**

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<td>Employee Address:</td>
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<tr>
<td>Mailing Address: (if different from above)</td>
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<tr>
<td>Dependent Address: (if different from above)</td>
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<tr>
<th>Field</th>
<th>Options</th>
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<tbody>
<tr>
<td>Employee Classification:</td>
<td>□ Admin/Conf</td>
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<tr>
<td>Employee Status:</td>
<td>□ Full Time</td>
</tr>
</tbody>
</table>

### SECTION B - BASIC LIFE INSURANCE AND BASIC ACCIDENTAL DEATH & DISMEMBERMENT

**Basic Life Insurance** - If applicable, your Educational Entity will automatically enroll you in this coverage. Coverage amounts are determined by your Educational Entity and/or employment group. If you have questions about this coverage, please check with your Educational Entity.

**Basic Accidental Death and Dismemberment** - If applicable, your Educational Entity will automatically enroll you in this coverage. Coverage amounts are determined by your Educational Entity and/or employment group. If you have questions about this coverage, please check with your Educational Entity.

### SECTION C - OPTIONAL LIFE INSURANCE ELECTIONS

**Employee Optional Life Insurance** - If applicable, you can enroll in benefit levels that range from $10,000 to $500,000, in increments of $10,000. The guarantee issue amount for active employees is $200,000. **A medical history statement is required for amounts over the guarantee issue amount.** Check with your Educational Entity to determine if this coverage is offered.

**New Hire Options:**  
**Check one box only**

- Guarantee Issue - $200,000 or less. If less, enter amount $__________
- Enroll in additional life insurance - Total requested amount $__________ (includes guarantee issue)

**Open Enrollment / Qualified Status Change Options:**  
**Check one box only**

- Enroll - Total requested amount $__________
- Change coverage from $__________ to $__________ TOTAL
- Cancel coverage

*created July 2009*
Spouse/Partner Optional Life Insurance - If applicable, you can enroll your spouse/partner in life insurance with benefit levels that range from $10,000 to $500,000. The guarantee issue amount is $30,000 for spouse/partner’s of active employees. A medical history statement is required for amounts over the $30,000 guarantee issue amount. You must enroll in Employee Optional Life to enroll your spouse in this coverage and the value of this plan cannot exceed the value of your coverage.

New Hire Options:
(Choose one box only)

☐ Guarantee Issue - $30,000 or less. If less, enter amount $______________
☐ Enroll in additional life insurance-
  Total requested amount $______________ (includes guarantee issue)

Open Enrollment / Qualified Status Change Options:
(Choose one box only)

☐ Enroll - Total requested amount $______________
☐ Change coverage from $______________ to $______________ TOTAL
☐ Cancel coverage

Child Optional Life Insurance - If applicable, you can enroll your child(ren) in life insurance with benefit levels that range from $2,000 to $10,000. All amounts are guarantee issue. You must enroll in Employee Optional Life to enroll your child(ren) in this coverage and the amount of Child Optional Life cannot exceed the amount of Employee Optional Life.

Options:
(Choose one box only)

☐ Enroll in coverage - ☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $10,000
☐ Change coverage from $______________ to $______________
☐ Cancel coverage

SECTION D - OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT ELECTIONS

Eugene School District 4J
does not offer
Optional Accidental Death & Dismemberment Plans.
SECTION E - MANDATORY SHORT TERM DISABILITY AND MANDATORY LONG TERM DISABILITY

Eugene School District 4J does not offer Short Term Disability plans.

Mandatory Long Term Disability - If applicable, your Educational Entity will automatically enroll you in this coverage. Coverage level is determined by your Educational Entity and/or employment group. If you have questions about this coverage, please check with your Educational Entity.

SECTION F - VOLUNTARY SHORT TERM DISABILITY AND VOLUNTARY LONG TERM DISABILITY

Eugene School District 4J does not offer Short Term Disability plans or Voluntary Long Term Disability plans.

SECTION G - 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.

<table>
<thead>
<tr>
<th>Name of Beneficiary or Trust</th>
<th>DOB</th>
<th>Relationship</th>
<th>Primary or Contingent</th>
<th>Percentage</th>
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SECTION H - 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