Medical, Dental, and Vision Enrollment and Change Form
Active Employee and Retiree Plan Year 2009

☐ New Hire ☐ Change ☐ Open Enrollment

SECTION A - EMPLOYEE INFORMATION

School District Name: Eugene School District 4J 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:	☐ Admin/Conf	☐ Licensed	☐ Classified	☐ Superintendent
Employee Status:	☐ Full Time	☐ Part Time	☐ Retired	

Qualified Status Change:	☐ New Hire	☐ Marriage	☐ Meets Domestic Partner eligibility
	☐ Divorce	☐ Birth/Adoption	☐ Termination of Domestic Partnership
Date: ______	☐ Dependent meets eligibility		☐ Death of spouse/dependent
	☐ Dependent ceases to meet eligibility		☐ Move causes loss of eligibility
Effective Date: ______ (determined by QSC date above, consult HR)	☐ Qualified Medical Child Support Order		☐ Employment status change which affects eligibility
	☐ Other ______		

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 medical 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. Complete Section D.	I wish to waive/decline the following benefits: **MEDICAL** ☐ **DENTAL** ☐ **VISION** ☐

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. If covering a domestic partner without a certificate, partner's children, or dependent by affidavit, a completed affidavit must be attached or on file (check with your district or educational entity for eligibility)

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 + / -	Last Name	First Name	MI	Birth Date (MM-DD-YY)	Relationship	Gender M	Gender F	Plan Med	Plan Den	Plan Vision
						☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐

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		
Policy Number	Group Number	Effective Date
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

Educational Entity Use Only
Approved by (initials): Approved change effective date:
Date: MyOEBB updated by (initials):

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

OREGON EDUCATORS
OEBB
BENEFIT BOARD

Life and Disability Enrollment and Change Form
Active Employee and Retiree Plan Year 2009

☐ **Qualified Status Change** ☐ **Open Enrollment**

SECTION A - EMPLOYEE INFORMATION

School District Name: Eugene School District 4J ______ 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:	☐ Admin/Conf	☐ Licensed	☐ Classified	☐ Superintendent
Employee Status:	☐ Full Time	☐ Part Time	☐ Retired	☐ COBRA

Qualified Status Change:

Date: ______

☐ New Hire ☐ Marriage ☐ Meets Domestic Partner Eligibility
☐ Divorce ☐ Birth/Adoption ☐ Termination of Domestic Partnership
☐ Dependent meets eligibility ☐ Death of spouse/dependent
☐ Dependent ceases to meet eligibility ☐ Employment status change which affects eligibility
☐ Other ______

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

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:
(Check 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*:**
(Check 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*:**
(Check 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.

Name of Beneficiary or Trust	DOB	Relationship	Primary or Contingent		Percentage
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

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 ____________

Educational Entity Use Only

Approved by (initials): Approved change effective date:

Date: MyOEBB updated by (initials):