

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 - COORDINATION OF BENEFITS 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):

Date:

Approved change effective 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 benefits or making a change, please mail this completed form to: OEBB, 1225 Ferry Street SE, Salem, OR 97301

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
			<input type="checkbox"/>		<input type="checkbox"/>	
			<input type="checkbox"/>		<input type="checkbox"/>	
			<input type="checkbox"/>		<input type="checkbox"/>	
			<input type="checkbox"/>		<input type="checkbox"/>	

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 OEGB's plan eligibility requirements or until I elect to change them subject to the terms of OEGB's plan. I have read the benefit materials and I understand the limitations and qualifications of the OEGB 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 fro 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 OEGB 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:
MyOEGB updated by (initials):