



# Midyear Change Form

Office use only	
Approved by:	_____
Approved date:	_____
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>

Employee information				
Last name	First name	Middle		
Employee ID, E number or Social Security number	Gender	Date of birth (mm/dd/yyyy)		
	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other			
Home phone number	Work phone number	Cell phone number		
<b>May OEBB send text messages to this number? Standard text message and data rates apply.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
Address	<input type="checkbox"/> Check if new address	Apartment or space#		
City	State	ZIP	County	
Personal email	Work email			
<b>Medicare eligible?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Are you serving or did you ever serve in the military?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>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?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Ethnicity (Select one):</b>	Hispanic	Non-Hispanic/Non-Latino	Refused	Unknown
<b>Race (Select at least one):</b>				
<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	
<input type="checkbox"/> White	<input type="checkbox"/> Other	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown	

## Tobacco usage (Responses in this section are required)

<b>Employee</b> In the last 12 months (Select one): <input type="checkbox"/> I have used tobacco products <input type="checkbox"/> I have <b>not</b> used tobacco products <input type="checkbox"/> I have never used tobacco products	<b>Spouse/Domestic partner</b> In the last 12 months (Select one): <input type="checkbox"/> I do not currently have a spouse/domestic partner <input type="checkbox"/> My spouse/domestic partner has used tobacco products <input type="checkbox"/> My spouse/domestic partner has <b>not</b> used tobacco products <input type="checkbox"/> My spouse/domestic partner has never used tobacco products
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## Qualifying status change event (Select One)

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/Annulment  Termination of Domestic Partnership  Death

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

## Dependent information

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, OEGB may consider that an intentional misrepresentation of a material fact, for which OEGB 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 OEGB 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 OEGB 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. OEGB's Affidavit of Domestic Partnership can be found online at: <http://www.oregon.gov/oha/OEGB/pages/Forms.aspx>

**Dependent A**  Enroll  Change  Remove  Medical  Vision  Dental

Relationship to employee  Spouse  Domestic partner  Child

Gender  M  F  Other Date of birth (mm/dd/yyyy) Social Security, HICN, or Tax ID number: Medicare eligible?  Y  N

Last name First name Middle

Address (if different from employee address) City State ZIP

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

<b>Dependent B</b>				<input type="checkbox"/> Enroll	<input type="checkbox"/> Change	<input type="checkbox"/> Remove	<input type="checkbox"/> Medical	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental		
Relationship to employee				<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	<input type="checkbox"/> Child					
Gender		Date of birth (mm/dd/yyyy)		Social Security, HICN, or Tax ID number:			Medicare eligible?				
<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Other						<input type="checkbox"/> Y	<input type="checkbox"/> N		
Last name			First name			Middle					
Address (if different from employee address)					City		State		ZIP		
<b>Ethnicity (Select one):</b>				Hispanic		Non-Hispanic/Non-Latino		Refused		Unknown	
<b>Race (Select at least one. If selecting more than one, circle one as primary):</b>											
<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American			<input type="checkbox"/> American Indian/Alaska Native			<input type="checkbox"/> Native Hawaiian/Other Pacific Islander				
<input type="checkbox"/> White	<input type="checkbox"/> Other			<input type="checkbox"/> Refused			<input type="checkbox"/> Unknown				

<b>Dependent C</b>				<input type="checkbox"/> Enroll	<input type="checkbox"/> Change	<input type="checkbox"/> Remove	<input type="checkbox"/> Medical	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental		
Relationship to employee				<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	<input type="checkbox"/> Child					
Gender		Date of birth (mm/dd/yyyy)		Social Security, HICN, or Tax ID number:			Medicare eligible?				
<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Other						<input type="checkbox"/> Y	<input type="checkbox"/> N		
Last name			First name			Middle					
Address (if different from employee address)					City		State		ZIP		
<b>Ethnicity (Select one):</b>				Hispanic		Non-Hispanic/Non-Latino		Refused		Unknown	
<b>Race (Select at least one. If selecting more than one, circle one as primary):</b>											
<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American			<input type="checkbox"/> American Indian/Alaska Native			<input type="checkbox"/> Native Hawaiian/Other Pacific Islander				
<input type="checkbox"/> White	<input type="checkbox"/> Other			<input type="checkbox"/> Refused			<input type="checkbox"/> Unknown				

<b>Double coverage surcharge info</b>	
Are any of your covered family members offered medical insurance as an employee through OEGB or PEBB?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are they enrolled in the OEGB or PEBB medical insurance offered? (if both answers are yes a \$5/ mo surcharge will be applied)	<input type="checkbox"/> Yes <input type="checkbox"/> No

# Healthcare plan selections

## Medical

Medical plan selection: \_\_\_\_\_

Write in plan selection

If enrolled in a Moda medical plan, each covered individual must choose a PCP 360 with Moda for that individual to receive the enhanced “coordinated” benefit if using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive the “non-coordinated” benefit if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the “out-of-network” level regardless of whether or not the individual has chosen a PCP 360 with Moda. A list of PCP 360 providers can be found at:

<https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml>

**If you are choosing to not enroll in an OEGB 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 OEGB 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 OEGB 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: \_\_\_\_\_

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

## Dental

Dental plan selection: \_\_\_\_\_

Write in plan selection

## 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

For any newly eligible employee, the Optional Employee Life has a guarantee issue\* enrollment amount of up to \$200,000 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 OEGB website at:

<http://www.oregon.gov/oha/OEGB/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 \$200,000)

Additional requested amount\*\* \$ \_\_\_\_\_ (\$10,000 increments up to \$300,000)

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.

#### Children optional life insurance

Enroll

Change enrollment

Decline coverage

Total requested amount \$ \_\_\_\_\_ (\$2,000 increments up to \$10,000 maximum)

### B. 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.

## 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 <input type="checkbox"/> OR <input type="checkbox"/>		Whole %
Name			Address			
City	State	ZIP	Relationship	Primary or contingent <input type="checkbox"/> OR <input type="checkbox"/>		Whole %
Name			Address			
City	State	ZIP	Relationship	Primary or contingent <input type="checkbox"/> OR <input type="checkbox"/>		Whole %
Name			Address			
City	State	ZIP	Relationship	Primary or contingent <input type="checkbox"/> OR <input type="checkbox"/>		Whole %

\*Affidavit Information: OEBC's Affidavit of Domestic Partnership can be found online at:

<http://www.oregon.gov/oha/OEBC/pages/Forms.aspx>

## Employee signature and authorization

I declare the dependents listed above and I are eligible for the coverages requested per OEBC 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](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](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](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 OEBC's eligibility requirements, or until I elect to change them subject to the provisions of OEBC'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 OEBC QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix at

<http://www.oregon.gov/oha/OEBC/Pages/QSC-Matrix.aspx>

I have read the benefit materials and I understand the limitations and qualifications of the OEGB 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 OEGB 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 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.

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Employee signature

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Date

**Submit this completed form to your payroll/benefits office.**

**Do not submit this form to OEGB.**