New Hire Enrollment

District Use Only
Approved by: _____
Approved date: _____
Effective date: _____

Use this form to enroll in benefits when first eligible. Submit to your Benefits@RSD7.net within 30 days of your Hire Date.

Employee information

Last name | First name | M.I.

Employee ID, E number or Social Security number | Gender ○ M ○ F ○ Other | Date of birth *(mm/dd/yyyy)*

Home phone number | Work phone number | Cell phone number

May OEBB send text messages to this number? Standard text message and data rates apply. ○ Yes ○ No

Address ☐ Check if new address | Apartment or space#

City | State | ZIP | County

Personal email | Work email

Medicare eligible? ○ Yes ○ No

Are you serving or did you ever serve in the military? ○ Yes ○ No

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? ○ Yes ○ No

Ethnicity *(Select one)*: ○ Hispanic ○ Non-Hispanic ○ 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

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

In this section, OEBB is collecting tobacco usage information for you and your spouse/domestic partner (if applicable). This information will be used to determine your premium amount(s) for Optional Employee and Optional Spouse/Domestic Partner Life plans through The Standard. **You must complete this section even if you do not enroll in these plans.**

Employee In the last 12 months *(select one)*:	**Spouse/Domestic partner** In the last 12 months *(select one)*:
○ I have used tobacco products	○ I do not currently have a spouse/domestic partner
○ I have ***not*** used tobacco products	○ My spouse/domestic partner has used tobacco products
○ I have never used tobacco products	○ My spouse/domestic partner has ***not*** used tobacco products ~
	○ My spouse/domestic partner has never used tobacco products

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

Dependent A

Enroll: ☐ 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

Dependent B

Enroll: ☐ 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

Dependent C

Enroll: ☐ 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 eeligible? ◯ 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

Dependent D

Enroll: ☐ 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

Double coverage surcharge info

Are any of your covered family members offered medical insurance as an employee through OEBB or PEBB? ◯ Yes ◯ No

Are they enrolled in the OEBB or PEBB medical insurance offered? *(If both answers are Yes, a $5 monthly surcharge will be applied.)* ◯ Yes ◯ 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 OEBB 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 OEBB 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 OEBB 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

As a newly eligible employee for your first time enrollment, 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 OEBB website at:
http://www.oregon.gov/oha/OEBB/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 ☐ Decline coverage

New hire/Newly eligible enrollment* $ _____ ($10,000 increments up to $200,000)

Additional requested amount above guarantee issue** $ _____ ($10,000 increments up to $300,000)

Total requested amount $ _____ ($500,000 maximum)

Spouse/domestic partner optional life insurance ☐ Decline coverage

New hire/Newly eligible enrollment* $ _____ ($10,000 increments up to $30,000)

Additional requested amount above guarantee issue** $ _____ ($10,000 increments up to $470,000)

Total requested amount $ _____ ($500,000 maximum)

Total requested amount must be equal to or less than employee optional life insurance coverage.

Child(ren) optional life insurance ☐ 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.

C. Voluntary long term care insurance

Employee Long Term Care (LTC) enrollment as a newly eligible employee in an established employment group that has offered LTC since 2014 has a guarantee issue* amount of up to $6,000 in monthly benefit, professional home care option for 3 or 6 year duration without having to submit medical history for enrollment approval.

Enrollment requests for unlimited duration, amount over $6,000, total home care, and 5% simple inflation options, enrollment after first eligible or a future date, and Spouse/Domestic Partner Long Term Care *will require the UNUM medical history statement to be filled out and submitted to UNUM.*

You can find a link to UNUM forms on the OEBB website:
http://www.oregon.gov/oha/OEBB/Pages/Forms.aspx

*You are required to submit a medical history statement on any coverage amount that is not guarantee issue or if you are requesting a change in enrollment coverage. Some employee groups may not be eligible.

Employee long term care*

☐ Decline Coverage

Plan option	Coverage amount	Duration
◯ Professional Home Care ◯ Total Home Care ◯ Professional Home Care – 5% inflation ◯ Total Home Care – 5% inflation	◯ $2,000 ◯ $5,000 ◯ $8,000 ◯ $3,000 ◯ $6,000 ◯ $9,000 ◯ $4,000 ◯ $7,000	◯ 3 Years ◯ 6 Years ◯ Unlimited

Spouse/domestic partner long term care*

☐ Decline Coverage

Plan option	Coverage amount	Duration
◯ Professional Home Care ◯ Total Home Care ◯ Professional Home Care – 5% Inflation ◯ Total Home Care – 5% inflation	◯ $2,000 ◯ $5,000 ◯ $8,000 ◯ $3,000 ◯ $6,000 ◯ $9,000 ◯ $4,000 ◯ $7,000	◯ 3 Years ◯ 6 Years ◯ Unlimited

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 ◯ OR ◯	Whole %	
Name			Address			
City	State	ZIP	Relationship	Primary or contingent ◯ OR ◯	Whole %	
Name			Address			
City	State	ZIP	Relationship	Primary or contingent ◯ OR ◯	Whole %	
Name			Address			
City	State	ZIP	Relationship	Primary or contingent ◯ OR ◯	Whole %	

*Affidavit Information: OEBB's Affidavit of Domestic Partnership can be found online at:
http://www.oregon.gov/oha/OEBB/pages/Forms.aspx

Employee signature and authorization

I declare the dependents listed above and I are eligible for the coverages requested per OEBB 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

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

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

I understand the benefit elections I make 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 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 OEBB QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix at:

http://www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx

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, 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 OEBB 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 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

Submit the completed form to Benefits@RSD7.net.

Do not submit this form to OEBB.