**Active Employee transitioning to Self-Pay Early Retiree: Use this form to update your benefits within 31 days of experiencing one of the status changes listed below in section 1.**

**1. What type of Early Retiree are you?**

|  |
| --- |
| [ ]  TYPE A – Active employee becoming self-pay early retiree (no employer contributions/stipend) |
| [ ]  TYPE B – Early retiree with employer contribution/stipend becoming self-pay early retiree (no employer contributions/stipend). |

**2. What would you like to do?**

|  |  |
| --- | --- |
| [ ]  No changes – keep all current enrollments | [ ]  Change my current medical plan to a lesser plan |
| [ ]  Cancel one or more OEBB benefit plans | [ ]  Remove one or more dependents  (Section 4 must be completed) |

**3. Member Information**

|  |  |  |
| --- | --- | --- |
| Last Name        | First Name        | MI   |
| Member ID, Social Security Number, or E Number      | Gender[ ]  Male [ ]  Female | Date of Birth (MM-DD-YYYY)      |
| [ ]  Check if new address | Contact Phone Number      | Contact Email      |
| Address       | Apt or Space #       |
| City        | State     | Zip      | County       |
| **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/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 |

**4. Cancel Dependent Coverage**

If you do not wish to cancel any dependent coverage, you may skip this section. Only list dependents if you wish to cancel their coverage. Federal law also requires you to supply the name and address for each spouse/domestic partner or dependent losing coverage so they may be notified of their COBRA rights.

Due to Federal Health Care Reform, OEBB is requesting Ethnicity, Race and Primary Race information for all members and dependents. Please indicate one ethnicity code and at least one race code for each dependent. If indicating more than one race code for a dependent, circle one as primary.

You must report to OEBB within 31 days after a person enrolled as your spouse, domestic partner or dependent child dependent becomes ineligible for benefits. If you make this report on time, the change will be effective the first of the month after your report. If you do not report this change on time, OEBB may consider your omission an intentional misrepresentation of a material fact, for which OEBB may terminate the dependent’s coverage effective the first of the month after eligibility was lost.

**\* NOTE:** All early retirees and spouses/domestic partners of early retirees lose eligibility for OEBB plans on the day they become eligible for Medicare due to age or disability. Notify OEBB immediately if you or your spouse/domestic partner is eligible for Medicare.

**Attach additional sheets if necessary.**

|  |  |  |
| --- | --- | --- |
| **DEPENDENT A** | [ ]  Change Enrollment [ ]  Remove Dependent | [ ]  Remove[ ]  Medical [ ]  Vision [ ]  Dental |
| Relationship to Member:[ ]  Spouse [ ]  Domestic Partner | Child of:[ ]  Member/Spouse [ ]  Domestic Partner | Overage Disabled Dependent of:[ ]  Member/Spouse [ ]  Domestic Partner |
| Gender [ ]  M [ ]  F | Date of Birth (mm-dd-yyy)      | Social Security, HICN, or Tax ID Number:      | Medicare Eligible?[ ]  Y [ ]  N |
| Last Name        | First Name      | MI   |
| Address (if different from Member address)       | City      | State   | Zip      |
| **Ethnicity** (Select One):[ ]  Hispanic [ ]  Non-Hispanic/Latino[ ]  Refused [ ]  Unknown | **Race** (Select at least one. If selecting more than one, circle one as primary):[ ]  Asian [ ]  American Indian/Alaska Native [ ]  Black/African American [ ]  Refused[ ]  Native Hawaiian/Other Pacific Islander [ ]  White [ ]  Other [ ]  Unknown |
| **DEPENDENT B** | [ ]  Change Enrollment [ ]  Remove Dependent | [ ]  Remove[ ]  Medical [ ]  Vision [ ]  Dental |
| Relationship to Member:[ ]  Spouse [ ]  Domestic Partner | Child of:[ ]  Member/Spouse [ ]  Domestic Partner | Overage Disabled Dependent of:[ ]  Member/Spouse [ ]  Domestic Partner |
| Gender [ ]  M [ ]  F | Date of Birth (mm-dd-yyy)      | Social Security, HICN, or Tax ID Number:      | Medicare Eligible?[ ]  Y [ ]  N |
| Last Name        | First Name      | MI   |
| Address (if different from Member address)       | City      | State   | Zip      |
| **Ethnicity** (Select One):[ ]  Hispanic [ ]  Non-Hispanic/Latino[ ]  Refused [ ]  Unknown | **Race** (Select at least one. If selecting more than one, circle one as primary):[ ]  Asian [ ]  American Indian/Alaska Native [ ]  Black/African American [ ]  Refused[ ]  Native Hawaiian/Other Pacific Islander [ ]  White [ ]  Other [ ]  Unknown |
| **DEPENDENT C** | [ ]  Change Enrollment [ ]  Remove Dependent | [ ]  Remove[ ]  Medical [ ]  Vision [ ]  Dental |
| Relationship to Member:[ ]  Spouse [ ]  Domestic Partner | Child of:[ ]  Member/Spouse [ ]  Domestic Partner | Overage Disabled Dependent of:[ ]  Member/Spouse [ ]  Domestic Partner |
| Gender [ ]  M [ ]  F | Date of Birth (mm-dd-yyy)      | Social Security, HICN, or Tax ID Number:      | Medicare Eligible?[ ]  Y [ ]  N |
| Last Name        | First Name      | MI   |
| Address (if different from Member address)       | City      | State   | Zip      |
| **Ethnicity** (Select One):[ ]  Hispanic [ ]  Non-Hispanic/Latino[ ]  Refused [ ]  Unknown | **Race** (Select at least one. If selecting more than one, circle one as primary):[ ]  Asian [ ]  American Indian/Alaska Native [ ]  Black/African American [ ]  Refused[ ]  Native Hawaiian/Other Pacific Islander [ ]  White [ ]  Other [ ]  Unknown |

**5. Medical, Dental, or Vision Plan Changes**

If you do not wish to change any health plan selections, you may skip this section.

|  |
| --- |
| **MEDICAL** |
| You may not change to a greater plan and you may not cancel medical coverage. You may keep your current plan by leaving this blank or change to a lesser plan: |
| **Change to this lesser medical plan:** |       |  |
|  |
| **DENTAL** |
| You may not change to a different dental plan. You may keep your current plan by leaving this blank or check the box to cancel dental coverage.  | [ ]  Cancel Dental |
|  |
| **VISION** |
| You may not change to a different vision plan. You may keep your current plan by leaving this blank or check the box to cancel dental coverage.  | [ ]  Cancel Vision |

**6. Cancel Optional Plans**

If you do not wish to change any health plan selections, you may skip this section.

**Plan offering and availability is determined by your employing entity. *Contact your employing entity for coverage information and to find out which optional plans are available to you.***

|  |
| --- |
| Things to consider:1. Your entity may automatically enroll you in a coverage amount for basic life insurance and/or basic AD&D.
2. Your entity determines which optional benefits it will offer and may not offer all the benefits on this form.
3. You may not enroll in Optional Plans or change your coverage amounts at this time, you may only cancel coverage. You must be enrolled in Optional Member Life in order to be enrolled in Optional Spouse/Domestic Partner Optional Life or Child Life.
 |
| **Member Optional Life Insurance**  | [ ]  Cancel Coverage |
| **Spouse/Domestic Partner Optional Life Insurance**  | [ ]  Cancel Coverage |
| **Child(ren) Optional Life Insurance**  | [ ]  Cancel Coverage |
| **Member Optional Accidental Death &Dismemberment (AD&D)** | [ ]  Cancel Coverage |
| **Spouse/Domestic Partner Optional AD&D**  | [ ]  Cancel Coverage |
| **Child(ren) Optional AD&D**  | [ ]  Cancel Coverage |

**7. Other Group Coverage**

If you are covered by another group medical plan, complete this section and provide proof of other group coverage to OEBB within five business days.

|  |  |
| --- | --- |
| [ ]  I do **not** have other group medical coverage *Skip to next section* | [ ]  I do have other group medical coverage *Complete this section* |
| Carrier      | Policy Number      | Group Number      |
| Primary Policy Holder      | Employer      | Effective Date (mm/dd/yyyy)      |

**9. 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 %    |

\*Affidavit Information: OEBB’s Affidavit of Domestic Partnership can be found online at:

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

**10. Member 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |       |  |
|  | Member Signature |  | Date |  |

|  |  |
| --- | --- |
| **Submit your completed form to:** | OEBB500 Summer Street NE, E-88Salem, OR 97301-4278 |