Lane Community College

Mid-Year Insurance Enrollment Change (OEBB) Classified

1. Employee Information

Social Security Number	L#

Last Name	First Name	Date of Birth	Gender
			☐ M ☐ F

Address	City	State	Zip

Preferred Phone	If cell phone, do you wish to receive text message reminders from OEBB? ☐ Yes ☐ No	Preferred Email

Are you eligible for Medicare due to age or disability? ☐ 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 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 one or more, circle one as primary): ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Refused ☐ Unknown

2. Dependent Information

Attach separate sheet if necessary.

Relationship Codes ("Rel. Code" below – Please indicate one per dependent.)
SP=Spouse, **CH**=Employee and/or Spouse's child, **DD**=Disabled Dependent, **DP**=Domestic Partner*, **DP CH**=Domestic Partner's Child*

Ethnicity Codes (Please indicate one per dependent below.)
1=Hispanic, **2**=Non-Hispanic/Non-Latino, **3**=Refused, **4**=Unknown

Race Codes (Please indicate one or more per dependent below. If more than one, please indicate one primary race in the next column.)
1=Asian, **2**=Black/African American, **3**=American Indian/Alaskan Native, **4**=Native Hawaiian/Other Pacific Islander, **5**=White, **6**=Other, **7**=Refused, **8**=Unknown

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 for each dependent and at least one race code for each dependent. If indicating more than one race code for a dependent, please also indicate in the next column which one of those race codes is the dependent's primary race.

Dependent A ☐ Add ☐ Drop	Medicare Eligible ☐ Yes ☐ No	* Race/Ethnicity:				
Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender ☐ M ☐ F

Dependent B ☐ Add ☐ Drop	Medicare Eligible ☐ Yes ☐ No	* Race/Ethnicity:				
Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender ☐ M ☐ F

Dependent C ☐ Add ☐ Drop	Medicare Eligible ☐ Yes ☐ No	* Race/Ethnicity:				
Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender ☐ M ☐ F

Dependent D ☐ Add ☐ Drop	Medicare Eligible ☐ Yes ☐ No	* Race/Ethnicity:				
Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender ☐ M ☐ F

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 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 as 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.

3. Tobacco Usage

This information will be used to determine your premium amount(s) for Optional Employee and Optional Spouse/Domestic Partner Life plans.	Please select one of the following:	Please select one of the following:
	☐ I currently use tobacco products. ☐ I have not used tobacco products in the past 12 months. ☐ I have never used tobacco products.	☐ I do not currently have a spouse or domestic partner. ☐ My spouse/domestic partner currently uses tobacco products. ☐ My spouse/partner has not used tobacco products in the past 12 months. ☐ My spouse/domestic partner has never used tobacco products.

4. Medical, Dental and Vision Plan Selection Indicate a selection for each plan type.

Medical Benefit Plan Selection	☐ Moda Plan 1 ☐ Moda Plan 2 ☐ Moda Plan 6 (w/ optional HSA) ☐ Kaiser Plan 1	☐ Decline Medical Explanation (required if declining; attach proof of other coverage if opting out to receive stipend):
Dental Benefit Plan Selection	☐ Delta Dental Plan 1 ☐ Delta Dental Plan 6 ☐ Willamette Dental Plan	☐ Decline Dental*
Vision Benefit Plan Selection	☐ Moda Opal ☐ VSP Choice Plus	☐ Decline Vision

*If you waive benefit coverage now, you may be subject to waiting period restrictions at a later date.

5. Voluntary Life Insurance

All coverage elections above the guarantee issue amount and/or beyond the guarantee issue period must be medically underwritten. Please mark the box for all coverage(s) you are applying for. By selecting "no", an application for coverage at a later date may require further medical information and/or physical exam, which may be at the member's own expense.

Voluntary Employee Coverage

☐ Life Only (in $10,000 increments): $_____

☐ Life & AD&D (in $10,000 increments): $_____

$200,000 Guarantee Issue

$500,000 Maximum Coverage

Employees must elect coverage in order to elect spouse/partner and/or dependent coverage. Total employee amount must be equal to or greater than requested amount for spouse/partner coverage.

Voluntary Spouse/Domestic Partner Coverage

☐ Life Only (in $10,000 increments): $_____

☐ Life & AD&D (in $10,000 increments): $_____

$30,000 Guarantee Issue

$500,000 Maximum Coverage

Voluntary Dependent Child Coverage

☐ Life Only (in $2,000 increments): $_____

☐ Life & AD&D (in $2,000 increments): $_____

$10,000 Maximum Coverage

Beneficiary Information

A contingent beneficiary will receive benefits only if the primary beneficiary does not survive you.

Name and Address	Relationship	Primary or Contingent	Percentage
		☐ ☐	%
		☐ ☐	%
		☐ ☐	%
		☐ ☐	%
		☐ ☐	%

6. Voluntary Long Term Care

All employee coverage elections above the guarantee issue amount and/or beyond the guarantee issue period must be medically underwritten. Additionally, all spouse/partner coverage must be medically underwritten. Please contact Human Resources to obtain the application for this process.

☐ Employee Coverage:	☐ Spouse/Partner Coverage:
Monthly Coverage (in $1000 increments): $_____	Monthly Coverage (in $1000 increments): $_____
Duration (check one): ☐ 3-Years ☐ 6-Years ☐ Lifetime	Duration (check one): ☐ 3-Years ☐ 6-Years ☐ Lifetime
Simple Inflation (check one): ☐ with ☐ without	Simple Inflation (check one): ☐ with ☐ without
Total Home Care (check one): ☐ with ☐ without	Total Home Care (check one): ☐ with ☐ without

7. 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

HUMAN RESOURCES USE ONLY

Coverage Effective Date _____ OEBB E # _____

☐ PDADEDN ☐ PDABCOV ☐ Infinisource