2016-17 Plan Year Open Enrollment Form

Entity Use Only	
Approved by	
Date Approved	
Effective Date	

Use this form to enroll in or change plans during Open Enrollment. Plan elections or changes will go into effect October 1, 2016 unless you are requesting coverage that requires carrier approval. Carrier approval coverage will go into effect October 1st or the first of the month following carrier approval, whichever is later.

If you are newly benefits eligible and your benefits become effective prior to October 1, 2016, you should also complete a "2016-17 Plan Year New Member Enrollment Form" to make benefit selections for the remainder of the 2015-16 Plan Year.

1. Member Information

Last Name	First Name			MI
Member ID, Social Security Number, or E Number	Gender ☐ Male ☐ Female		Date of Birth (mm-dd-yyyy)	
Home Phone	Work Phone		Personal Email	
☐ Check if new address	Work 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

2. Tobacco Usage (Responses in this section are required)

MEMBER **In the last 12 months (Select one):**	SPOUSE/DOMESTIC PARTNER **In the last 12 months (Select one):**
☐ I have used tobacco products ☐ I have ***not*** used tobacco products ☐ I have never used tobacco products	☐ I do not currently have a spouse/domestic partner ☐ My spouse/domestic partner has used tobacco products ☐ My spouse/domestic partner has ***not*** used tobacco products ☐ My spouse/domestic partner has never used tobacco products

3. Healthy Futures Participation (Incentivized Deductible Program)

A. Healthy Actions Reporting

I and my Spouse/Domestic Partner (if applicable) have completed the Health Assessment and have completed two Healthy Actions reported below by August 15, 2016:

MEMBER	SPOUSE/DOMESTIC PARTNER
☐ I ***do not*** have a Spouse/Domestic Partner enrolled in medical coverage	☐ I have a Spouse/Domestic Partner enrolled in medical coverage
☐ Healthy Team Healthy U (Counts as two actions)	☐ Healthy Team Healthy U (Counts as two actions)
☐ WeightWatchers ☐ Other (Fill in action below)	☐ WeightWatchers ☐ Other (Fill in action below)
☐ Tobacco Cessation	☐ Tobacco Cessation
☐ MoodHelper ☐ Other (Fill in action below)	☐ MoodHelper ☐ Other (Fill in action below)
☐ I did not complete actions	☐ I did not complete actions

3. Healthy Futures Participation (Incentivized Deductible Program)

B. Agreement to Participate

1. I understand that I and my spouse/domestic partner (if applicable) must agree to participate and enroll in a Healthy Futures plan during Open Enrollment 2016 to receive the incentivized deductible for the 2016-17 Plan Year.
2. I understand by agreeing to participate and enrolling in a Healthy Futures plan my spouse/domestic partner (if applicable) and I will need to complete an individual Health Assessment for medical plan enrolled in, either Kaiser Permanente or Moda Health between August 15 – October 15, 2016, and I have informed my spouse/domestic partner (if applicable) to complete the Health Assessment between August 15 – October 15, 2016.
3. I understand by agreeing to participate and enrolling in a Healthy Futures plan my spouse/domestic partner (if applicable) and I will individually need to complete two healthy actions by August 15, 2017, and I have informed my spouse/domestic partner (if applicable) to complete by August 15, 2017.
4. I understand that if I or my spouse/domestic partner (if applicable) fail to complete my/our individual Health Assessment between August 15 – October 15, 2016, my/our deductible will revert to the non-incentive amount retroactive to October 1, 2016.
5. I understand that if I or my spouse/domestic partner (if applicable) fail to complete my/our individual two healthy actions by August 15, 2017, I/we will be ineligible for the Healthy Futures lower deductible for the 2017-18 Plan Year.
6. I and my spouse/domestic partner (if applicable) will complete two healthy actions before August 15, 2017, as follows:
   a. If my/his or her health assessment indicates that my/his or her weight is a risk to my/his or her health, one of my/his or her healthy actions will address this risk. Some examples of healthy actions to address this risk are:
      - Participate in Weight Watchers
      - Nutritional counseling by a registered dietician
      - A program of physical activity
      - An assessment and action plan developed by my health care provider
      - Participation in Healthy Team Healthy U, a team-based health engagement program sponsored by OEBB
   b. If my/his or her health assessment indicates that tobacco use is a risk to my/his or her health, one of my/his or her healthy actions will address this risk. Some examples of healthy actions to address this risk are:
      - Participate in a tobacco cessation program - either Quit for Life? or another therapy recommended by my healthcare provider
      - Work through the e-tools on your medical carrier's website on tobacco cessation
      - Participation in Healthy Team Healthy U, a team-based health engagement program sponsored by OEBB
   c. If weight or tobacco are not health risks for me (or my spouse/domestic partner), I/he or she will take action to address other health risks identified in my/his or her assessment, or to maintain my/his or her current good health. Some examples include:
      - Other online programs available through the carriers, like "Fire Up Your Feet" or "Moodhelper" through Kaiser, or "Fit It In" through Moda Health
      - Participate in a school employee wellness activity or a team-based/worksite-based health promotion program
      - Participate in a walking program sponsored by an association or club, PTA, or health club
      - E-lessons on topics of your choice (available on your medical carrier's website)
      - Preventive services recommended for your age by the U.S. Preventive Services Taskforce (annual dental cleaning, mammogram, colonoscopy, etc.)
      - Participation in Healthy Team Healthy U, a team-based health engagement program sponsored by OEBB
7. I understand that the actions listed above are just examples. There are many actions that support good health which will qualify.
8. I understand that if a licensed medical professional from Kaiser or Moda Health calls me or my spouse/domestic partner (if applicable) about a diagnosed chronic condition or other illness based on information submitted by my/his or her healthcare provider, I/he or she will accept or return the call to learn about potential support services for managing my/his or her condition.
9. I and my spouse/domestic partner (if applicable) will report the actions I/he or she take for Healthy Futures during the next Open Enrollment period.
10. I understand that I and my spouse/domestic partner (if applicable) can request to have answers from me and my spouse/domestic partner's (if applicable) Health Assessment shared with my/his or her primary care provider with my/his or her approval.
11. I understand that if a medical condition or disability makes it unreasonably difficult for me or my spouse/domestic partner (if applicable) to achieve a standard described above, or if attempting to do so is medically inadvisable, a reasonable alternative to the standard will be provided. I further understand that I may contact OEBB at 888-469-6322, and OEBB will work with me or my spouse/domestic partner (if applicable), (and if desired, with my/his or her doctor) to find a reasonable alternative that is right for me/him or her in light of my/his or her health status.

Reminder – If you cover a spouse/domestic partner on your medical plan, both of you need to complete the steps to earn the reward. By agreeing to participate, you are agreeing to:

- Complete a Health Assessment between August 15 – October 15, 2016
- Take two Healthy Actions by August 15, 2017
- Report those Healthy Actions during Open Enrollment 2017

I acknowledge by agreeing to participate in the Healthy Futures Program and enrolling in a Healthy Futures Medical Plan for the 2016-17 plan year, if I and/or my spouse/domestic partner (if applicable) fail to complete the individual health assessment between August 15 – October 15, 2016, my/our 2016-17 deductible will be adjusted to the non-incentivized higher amount retroactively effective October 1, 2016, and if I/we fail to complete two health actions by August 15, 2017 or fail to report two healthy actions during Open Enrollment 2017, I/we will be ineligible to enroll in the Health Futures Program for the 2017-18 plan year.

☐ YES, I/we agree to participate in Healthy Futures ☐ NO, I/we do not agree to participate in Healthy Futures

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4. Dependent Information (Attach additional sheets if necessary)

You must report to OEBB 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)

*Affidavit Information: If you are adding a domestic partner by OEBB Affidavit, you must submit the affidavit to OEBB 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 ☐ Change Enrollment ☐ Remove Dependent ☐ Enroll ☐ 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 ☐ Enroll ☐ 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 ☐ Enroll ☐ 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

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5. Plan Selection

MEDICAL

Medical Plan Selection: _____

Write in plan selection.

If selecting a Moda Medical Synergy/Summit Plan, prior to the coverage start date you must contact Moda Health to select a Medical Home Provider for each covered member. A list of Medical Home 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** You will receive a financial incentive from your employing entity to not enroll in medical coverage. **By selecting this option, I confirm all eligible dependents have other group coverage.**

You MUST have other employer-sponsored group medical coverage. Participation or enrollment in the Oregon Health Plan, Medicaid, Veterans' Administration Benefit Programs, Medicare, or Student Health Insurance does NOT qualify for OEBB opt-out.

You must provide proof of other group coverage to your employing entity 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** You will ***not*** receive a financial incentive from your employing entity regardless of whether or not you have other medical coverage.

Note: Many employing entities do not offer a financial incentive, in those cases you should select "Waive."

DENTAL

Dental Plan Selection: _____ ☐ Decline Dental

Write in plan selection.

VISION

Vision Plan Selection: _____ ☐ Decline Vision

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

LATE ENROLLMENT PENALTY

I understand if I decline Dental and/or Vision coverage when initially eligible or allow coverage to lapse, then choose to enroll in one or both of these plans at a future Open Enrollment period, I and any dependents enrolled will be subject to a 12-month waiting period on these plans for services other than basic services (cleanings, x-rays, and exams only for dental; exam only for vision).

_____ _____

Member Signature Date

500 Summer Street NE, E-88
Salem, OR 97301-1063
Phone: 888-469-6322 Fax: 503-378-5832

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6. Optional Plans (Member paid voluntary payroll deduction plans.)

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.*

A. Optional Life Insurance

As a newly eligible member for your first time enrollment the Optional Member Life has a guarantee issue enrollment amount of up to $100,000 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.
** You are required to submit a medical history statement on any coverage amount that is not guarantee Issue.

Member Optional Life Insurance ☐ Decline Coverage

New Hire/Newly Eligible Enrollment*	$ _____	($10,000 increments up to $100,000)
Additional Requested Amount Above Guarantee Issue**	$ _____	($10,000 increments up to $400,000)
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 $400,000)
Total Requested Amount	$ _____	($500,000 maximum)

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

Child(ren) Optional Life Insurance ☐ Decline Coverage

Total Requested Amount $ _____ ($2,000 increments up to $10,000 maximum)

Medical history is not required, you must enroll in member optional life to enroll your child(ren) in this coverage.

B. Optional Accidental Death & Dismemberment (AD&D) Insurance

Member Optional AD&D ☐ Decline Coverage

Total Requested Amount $ _____ ($10,000 increments up to $500,000 maximum)

Medical history is not required.

Spouse/Domestic Partner Optional AD&D ☐ Decline Coverage

Total Requested Amount $ _____ ($10,000 increments up to $500,000 maximum)

Medical history is not required. Total requested amount must be equal or less than member optional AD&D coverage.

Child(ren) Optional AD&D ☐ Decline Coverage

Total Requested Amount $ _____ ($2,000 increments up to $10,000 maximum)

Medical history is not required. You must enroll in member optional AD&D to enroll your child(ren) in this coverage.

C. 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.

Voluntary Long Term Disability ☐ Enroll For Coverage ☐ Decline Coverage

Long Term Disability plans pay monthly benefits with benefits starting after 60 or 90 day waiting periods depending upon plan enrollment.

D. Voluntary Long Term Care Insurance

Member Long Term Care enrollment as a newly eligible member has guarantee issue amounts 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.

Member Long Term Care* ☐ Decline Coverage

Plan Option		Coverage Amount			Duration
☐ Professional Home Care	☐ Professional Home Care – 5% Inflation	☐ $2,000	☐ $5,000	☐ $8,000	☐ 3 Years
☐ Total Home Care	☐ Total Home Care	☐ $3,000	☐ $6,000	☐ $9,000	☐ 6 Years
		☐ $4,000	☐ $7,000		☐ Unlimited

Spouse/Domestic Partner Long Term Care* ☐ Decline Coverage

Plan Option		Coverage Amount			Duration
☐ Professional Home Care	☐ Professional Home Care – 5% Inflation	☐ $2,000	☐ $5,000	☐ $8,000	☐ 3 Years
☐ Total Home Care	☐ Total Home Care	☐ $3,000	☐ $6,000	☐ $9,000	☐ 6 Years
		☐ $4,000	☐ $7,000		☐ Unlimited

7. 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

8. Member Signature and Authorization

I declare the dependents listed above and I are eligible for the coverages requested per OEBB Administrative Rule (OAR)-Division. 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 OEBB's HB2557 Coordinator 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 experience a QSC; then I am subject to the restrictions of the OEBB QSCs. I have reviewed and understand the Qualified Status Change (QSC) Matrix which can be found 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. This is a self-pay program, I agree for monthly payments to be deducted from my financial institution by the date specified on the back of the ACH form, or my coverage will terminate. I will not be able to reinstate coverage until the next open enrollment period (if I requalify) or I 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 this completed form to your Employing Entity.

Do not submit this form to OEBB.