



**2021-2022
Plan Year
New Hire Enrollment Form**

Employer Use Only

Approved by _____

Date Approved _____

Effective Date _____

Use this form to enroll in benefits when first eligible. Submit to your employer.

1. Employee Information

Last Name		First Name		MI
Employee ID, Social Security Number, or E Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm-dd-yyyy)
Home Phone	Work Phone		Cell Phone	
Personal Email		Work Email		
Address				Apt or Space #
City		State	Zip	County
Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you serving or did you ever serve in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," do you authorize OEGB to send your name and address to the Oregon Department of Veterans' Affairs (ODVA) for the purpose of receiving benefit information?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Ethnicity (Select One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown				
Race (Select at least one. If selecting more than one, circle one as primary): <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				

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

In this section, OEGB 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):
<input type="checkbox"/> I have used tobacco products <input type="checkbox"/> I have not used tobacco products <input type="checkbox"/> I have never used tobacco products	<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 not used tobacco products <input type="checkbox"/> My spouse/domestic partner has never used tobacco products

3. Dependent Information (Attach additional sheets if necessary)

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 member's coverage effective the first of the month after eligibility was lost.

<p>If listing a Domestic Partner as a dependent, indicate the type of Domestic Partnership*:</p> <p><input type="checkbox"/> By OEGB Affidavit of Domestic Partnership** <input type="checkbox"/> By Registered Certificate (Copy not required)</p> <p>* Domestic partner eligibility rules may vary by employer – verify with your benefits administrator before enrolling.</p> <p>**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</p>
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DEPENDENT A					Enroll: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental				
Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			Child of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			Overage Disabled Dependent of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy)		Social Security, HICN, or Tax ID Number:				Medicare Eligible? <input type="checkbox"/> Y <input type="checkbox"/> N		
Last Name			First Name				MI		
Address (if different from employee address)					City		State	Zip	
Ethnicity (Select One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			Race (Select at least one. If selecting more than one, circle one as primary): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown						
DEPENDENT B					Enroll: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental				
Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			Child of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			Overage Disabled Dependent of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy)		Social Security, HICN, or Tax ID Number:				Medicare Eligible? <input type="checkbox"/> Y <input type="checkbox"/> N		
Last Name			First Name				MI		
Address (if different from Employee address)					City		State	Zip	
Ethnicity (Select One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			Race (Select at least one. If selecting more than one, circle one as primary): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown						
DEPENDENT C					Enroll: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental				
Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			Child of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			Overage Disabled Dependent of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy)		Social Security, HICN, or Tax ID Number:				Medicare Eligible? <input type="checkbox"/> Y <input type="checkbox"/> N		
Last Name			First Name				MI		
Address (if different from Employee address)					City		State	Zip	
Ethnicity (Select One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			Race (Select at least one. If selecting more than one, circle one as primary): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown						
DEPENDENT D					Enroll: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental				
Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			Child of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			Overage Disabled Dependent of: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Domestic Partner			
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy)		Social Security, HICN, or Tax ID Number:				Medicare Eligible? <input type="checkbox"/> Y <input type="checkbox"/> N		
Last Name			First Name				MI		
Address (if different from Employee address)					City		State	Zip	
Ethnicity (Select One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			Race (Select at least one. If selecting more than one, circle one as primary): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown						



4. Plan Selection

MEDICAL

Medical Plan Selection: _____

Write in plan selection.

OPT-OUT, (must provide proof of other medical and meet requirements):

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 all your eligible dependents **MUST** have other employer-sponsored group medical coverage. 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)

VISION

Vision Plan Selection: _____

Decline Vision

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

DENTAL

Dental Plan Selection: _____

Decline Dental

Write in plan selection.

DENTAL LATE ENROLLMENT PENALTY

I understand if I **decline dental coverage** when initially eligible or allow coverage to lapse, then choose to enroll at a future Open Enrollment period, any dependents enrolled and I will be subject to a 12-month waiting period, meaning only diagnostic and preventive care (cleanings, x-rays, and exams) will be covered for the first 12 months of dental coverage.

Employee Signature

Date



5. 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 \$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.

Employee 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 employee optional life insurance coverage.

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

Employee 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 employee optional AD&D 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, up to 6 weeks, depending upon employee qualification.

Mandatory Long Term Disability

Enroll For Coverage

(All Eligible Employees must enroll in LTD)

Long Term Disability plans pay monthly benefits with benefits starting after a 60 day waiting period.



D. Voluntary Long Term Care Insurance

Employee Long Term Care enrollment as a newly eligible employee 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 OEBC website:

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

* You are required to submit a medical history statement on any coverage amount that is not guarantee issue.

Employee Long Term Care*						<input type="checkbox"/> Decline Coverage	
Plan Option		Coverage Amount			Duration		
<input type="checkbox"/> Professional Home Care	<input type="checkbox"/> Professional Home Care – 5% Inflation	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$8,000	<input type="checkbox"/> 3 Years		
<input type="checkbox"/> Total Home Care	<input type="checkbox"/> Total Home Care	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$9,000	<input type="checkbox"/> 6 Years		
		<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$7,000		<input type="checkbox"/> Unlimited		
Spouse/Domestic Partner Long Term Care*						<input type="checkbox"/> Decline Coverage	
Plan Option		Coverage Amount			Duration		
<input type="checkbox"/> Professional Home Care	<input type="checkbox"/> Professional Home Care – 5% Inflation	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$8,000	<input type="checkbox"/> 3 Years		
<input type="checkbox"/> Total Home Care	<input type="checkbox"/> Total Home Care	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$9,000	<input type="checkbox"/> 6 Years		
		<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$7,000		<input type="checkbox"/> Unlimited		

6. 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	Whole %		
				<input type="checkbox"/> OR <input type="checkbox"/>			
Name		Address					
City	State	Zip	Relationship	Primary or Contingent	Whole %		
				<input type="checkbox"/> OR <input type="checkbox"/>			
Name		Address					
City	State	Zip	Relationship	Primary or Contingent	Whole %		
				<input type="checkbox"/> OR <input type="checkbox"/>			
Name		Address					
City	State	Zip	Relationship	Primary or Contingent	Whole %		
				<input type="checkbox"/> OR <input type="checkbox"/>			

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

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

7. Employee Signature and Authorization

500 Summer Street NE, E-88,
Salem, OR 97301-1063



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

<http://www.oregon.gov/oha/OEGB/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.

Employee Signature

Date

Submit the completed form to your employer.

Do not submit this form to OEGB.