

Dependent Eligibility

Eligible dependents who are covered on a retiring employee's plan(s) at the time of retirement can continue to be covered as long as they meet the definition of an eligible dependent. This is until they become eligible for Medicare due to age or disability.

When an Early Retiree becomes eligible for Medicare coverage due to age or disability, any currently enrolled eligible dependents may continue OEGB medical, dental and vision coverage until they no longer meet eligibility requirements or become eligible for Medicare due to age or disability, whichever occurs first. The eligible dependents must confirm their intent to continue coverage with the employing entity benefits administrator within 60 days of the Early Retiree becoming eligible for Medicare.

Dependents can only be added to an Early Retiree's benefit plans within 31 days of a Qualified Status Change (QSC) event. Open enrollment period changes are limited to plan selection changes only.

Additional Resources

Qualified Status Change (QSC) Event Matrix
www.oregon.gov/oha/OEGB/Pages/QSC-Matrix.aspx

Frequently Asked Questions
www.oregon.gov/oha/OEGB/pages/faqs.aspx

Plan Comparisons & Rate Information
www.OEGBplandocs.com

View Current Enrollments
www.OEGBenroll.com

Medicare/SHIBA
<https://healthcare.oregon.gov/shiba>

PERS
www.oregon.gov/PERS

The Standard (Life and Disability)
www.standard.com/mybenefits/oebb

COBRA/Benefit Help Solutions
<http://benefithelp.com>
1-800-556-2230



Early Retiree Resources

A guide for Early Retirees and those planning for retirement.

Oregon Educators Benefit Board

500 Summer St NE, E-88
Salem, Oregon 97301-1063
1-888-469-6322
Fax: 503-378-5832
OEGB.Benefits@oregon.gov

Preparing for Early Retirement

As an Early Retiree, the OEBB coverages you have in place on the date of your retirement determine what you can continue into retirement.

Make sure you are enrolled in the medical, dental and/or vision plans you want when you retire. Retirement is not considered a Qualified Status Change (QSC) so you cannot add or change plans at the time of retirement. You can change plans if there are other plans available to you during the annual open enrollment period, but you will not be able to **add any type** of benefit plan in which you were not previously enrolled. The only exception would be if, as an active employee, you waived or opted-out of OEBB medical coverage because you were covered on another medical plan available through OEBB or on another school district plan. Under these circumstances, you will be allowed to enroll in an OEBB Early Retiree medical plan if you lose coverage under your spouse/domestic partner's medical plan and you request to add the coverage within 31 days of losing that other qualified coverage.

You can make certain changes to your optional coverages, such as life or AD&D, at the time of retirement. You can maintain, decrease, or cancel these coverages. You cannot increase any optional life or AD&D coverage at the time of retirement or during future open enrollment periods as a retiree. Make sure you are covering any eligible dependents you will want to continue covering on your medical, dental, and/or vision plans as an Early Retiree. You won't have the ability to add dependents during open enrollment periods once you've retired. You can only add dependents within 31 days following a Qualified Status Change (QSC) that allows this type of election change.

Ready to Retire

Notify your employing entity at least two weeks before your retirement date whether you intend to continue your enrollment in OEBB plans as an Early Retiree. If you decide not to continue any OEBB benefits upon retiring, you will not be able to enroll in these plans at a future date.

If you choose not to enroll in Early Retiree plans, or waive some or all coverage at retirement, you will not be able to add that coverage back during future open enrollment periods. However, if you "opted out" because you have other OEBB-sponsored group coverage through a spouse or domestic partner and then lose that coverage, this would be a valid Qualified Status Change (QSC) event allowing you to add the coverage if you notify your employing entity within 31 days of the qualifying event.

Contact your employing entity's human resources or payroll office for further information on available coverage, costs, payment arrangements and requirements. COBRA coverage is available to retirees in lieu of OEBB Early Retiree plans. COBRA coverage is available for up to 18 months from the date your coverage ends as an active employee. There is a two percent administrative fee for coverages continued under COBRA. All continuous coverage requirements and change limitations that apply to moving from active employee coverage to Early Retiree coverage also apply to moving from coverage continued under COBRA to Early Retiree coverage.

Becoming Eligible for Medicare

You become eligible for Medicare on the first of the month **prior** to your 65th birthday. If your birthday is on the first day of a month, you become Medicare-eligible a full month prior to turning age 65. You can also become eligible for Medicare due to disability at any age.

Early Retirees and eligible dependents of Early Retirees can continue OEBB coverage until the date they become Medicare-eligible. Once an Early Retiree or eligible dependent becomes Medicare-eligible due to age or disability, the OEBB coverage must end. Early retirees must notify their employing entity as soon as possible if they or a dependent become Medicare-eligible due to disability.

The only exception is if the individual (Early Retiree or dependent) becomes eligible for Medicare due to End Stage Renal Disease (ESRD). Coverage can be continued for 30 months.

You can enroll in Medicare up to three months in advance of becoming eligible. Failure to enroll in a timely manner may result in future penalties. Go to <http://www.medicare.gov/> for more information about Medicare.

If the employing entity allows it, Medicare-eligible members may elect to continue dental coverage only. Continuation of medical, pharmacy, vision, life and/or AD&D coverage is not allowed. In addition, at the time the retiree turns 65 and loses eligibility for life and AD&D coverage, dependents of the retiree can no longer continue on the group life and/or AD&D coverage through OEBB.

Many of these coverages can be converted or ported when OEBB coverage ends. You should contact The Standard directly for more information on these options.



To: Early Retirees currently enrolled in an Oregon Educators Benefit Board Insurance Plan
Subject: Benefits administration shift from your employing entity to Oregon Educators Benefit Board

Your employing entity has chosen the option to have OEBB (Oregon Educators Benefit Board) administer the monthly premium payments and benefits administration for your early retiree group. You have been identified as a member who is currently enrolled in a group health plan offered by your employing entity through OEBB.

What does this mean for you? You will no longer make your monthly premium payments directly to your employing entity, or to a third party administrator. If your employing entity contracted with another organization to administer your employee group. You will now be making your monthly premium payment directly to OEBB, thus eliminating the extra time and cost to the educational entity.

How to begin? Included in this packet you will see an Early Retiree Enrollment form. This form needs to be completed and mailed or faxed back to OEBB. In section 1 of this form you will see three different categories of Early Retirees.

- *Active to OEBB Administration Early Retiree* – check this box if you are currently an Active employee at your employing entity but are moving over to a fully self-paid Early Retiree status.

Continue completing the rest of the enrollment form as an Active to OEBB Administration Early Retiree. Please be sure to include your email address on your enrollment form. This is how your new Monthly Billing Statement will be delivered to you. If you do not have an email account, complete as “none” and your Monthly Billing Statement will be mailed to you.

OEBB is requesting all Early Retirees submit payment by Direct Debit Payments (ACH Debit). ACH Debit is free and a no-hassle way to pay your monthly insurance premiums. Funds will be withdrawn for your monthly premiums directly from your checking or savings account on the **2nd business day** of each month. OEBB requires 15 days to get your banking information set up and submit a zero dollar pre-note to your bank. A pre-note ensures OEBB has established a clear communication with your Financial Institution. Included in this packet is an Automatic Debit Authorization form. Please complete this form, send a voided check along with the form and return it to OEBB **within two weeks of the date on this letter.**

Please review the OAR rules for Division 65 (posted on our website) which outline our administrative guidelines for Early Retiree groups:

<http://www.oregon.gov/oha/OEBB/Pages/Admin-Rules.aspx>

What happens if I do not return my Early Retiree Enrollment and ACH Debit Forms? Your employing entity has terminated your benefits with an effective date of **September 30th of your current**

plan year (if retiring before the end of the school year, contact Benefits at ext. 5818 for your benefit end date). Failure to return the requested forms in a timely manner will cause you and your dependents to lose OEGB benefits.

Contacting OEGB for Assistance? If you need assistance with completion of your forms or have any payment or benefit-related questions, contact the OEGB member services team by one of the following:

Phone: 888-4My-OEGB (888-469-6322)
Email: oebb.benefits@oregon.gov
Fax: 503-378-5832
Mail: Oregon Educators Benefit Board
500 Summer Street NE, E-88
Salem, OR 97301-1063

OEGB looks forward to being able to support you as you continue your OEGB benefits as an early retiree of one of the many participating employing entities.

Sincerely,



Kathy Loretz
Director
OREGON HEALTH AUTHORITY
Health Policy and Analytics
Oregon Educators Benefit Board
Public Employees' Benefit Board



Self-Pay Early Retiree Enrollment Packet Q&A

Q: What is a “Self-Pay Early Retiree?”

A: An “Early Retiree” is anyone who retires prior to being eligible for Medicare. “Self-Pay” means your former employer does not contribute any funds toward your insurance premiums and you are responsible for paying the full premium for any coverage you elect.

Q: What are my plan options if I am currently paying all my premiums as an Early Retiree?

A: If you are currently an Early Retiree paying all your premiums, you will come over to OEGB with your current plans. Just like when you were paying your premiums through your former employer or a contracted third party administrator, you will have the option of making certain plan changes allowed to Early Retirees during the annual Open Enrollment period.

Q: My stipend (or employer contribution toward my premiums) ended when I moved over to OEGB. What changes can I make to my plans?

A: You are allowed to make the following plan changes:

- Medical Plans
 - Change to a less expensive plan
 - Cancel coverage for spouse/domestic partner and/or eligible dependent child(ren)
- Dental and Vision Plans
 - Cancel coverage
 - Cancel coverage for your spouse/domestic partner and/or eligible dependent child(ren)

NOTE: If you were previously paying all your premiums to your educational entity and OEGB is simply taking over the administration of your benefits, you are not allowed to make any changes at this time.

Q: How much do OEGB plans cost?

A: All OEGB plans and costs are available on the OEGB website:

<https://www.oregon.gov/oha/OEGB/Pages/Plans-Offered.aspx>

Q: Who qualifies as a dependent child?

A: An eligible Early Retiree’s, spouse’s, or domestic partner’s biological son, daughter, adopted child, child placed for adoption, or legally placed child, who is 25 or younger on the first day of the coverage month. An eligible Early Retiree must provide the required custody or legal documents to OEGB showing proof of adoption, legal guardianship or other court order if enrolling a child for whom the Early Retiree, spouse, or domestic partner is not the biological parent. Grandchildren are only eligible when the eligible Early Retiree is the legal guardian or adoptive parent of the grandchild.

Q: Do I need to enroll? If so, how do I enroll?

A: If you were previously paying all your premiums to your employing entity and OEGB is simply taking over the administration of your benefits, you are not allowed to make any plan changes at this time and do not need to enroll. Your current enrollments will continue provided you submit payment authorization by the date required (see below for payment authorization instructions).

If you match one of the following criteria, you are allowed certain changes; therefore you will need to submit an enrollment form to let OEGB know whether you want to make any changes at this time or keep your enrollments as they are:

- You are changing from an active employee to early retiree, or
- You previously had a stipend or employer contribution paying part of your early retiree premium and now need to self-pay your full premium

The changes you are allowed to make are:

- Medical Plans
 - Change to a less expensive plan
 - Cancel coverage for spouse/domestic partner and/or eligible dependent child(ren)
- Dental and Vision Plans
 - Cancel coverage
 - Cancel coverage for your spouse/domestic partner and/or eligible dependent child(ren)

Complete the enclosed Early Retiree Enrollment Form and submit to OEGB:

By Mail:

OEGB, Early Retiree Benefits
500 Summer Street NE, E-88
Salem, OR 97301-1063

By Fax:

503-378-5832

This form must be completed, signed and returned within 31 days of the day you became an early retiree or lost the stipend through your former employer.

Q: If I enroll, how do I make my premium payments and when are they due?

A: All payments are required to be made through an Electronic Funds Transfer (EFT). Complete and submit the enclosed ACH Debit Form and a voided check to:

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

If you need another copy of the form, you can request one by calling your former employer or OEGB Member Services at 888-469-6322.

Q: What if I don't maintain an account with a financial institution?

A: Call OEBB Member Services at 888-469-6322 to discuss making other arrangements.

Q: Is it possible to enroll or change my plan choices outside of the Open Enrollment Period?

A: Certain life events allow members to make changes to their benefit enrollments outside of the Open Enrollment Period. These life events are called Qualified Status Change (QSC) events. Experiencing a QSC event is the only way to enroll or make certain changes outside of the Open Enrollment Period.

Q: What are the OEBB Qualified Status Change (QSC) events?

A: A complete matrix of QSC events and the changes they allow can be found on the OEBB website:

<https://www.oregon.gov/oha/OEBB/Policies/QSCMatrix.pdf>

Q: If I experience a QSC, what should I do to enroll or change my elections?

A: If you experience a QSC event, you must submit a Midyear Change Form to OEBB *no later than 31 days from the date of the QSC event* to enroll or make election changes. The form can be found on the Forms page of the OEBB website:

<http://www.oregon.gov/oha/OEBB/Forms/Midyear-Change-Form.docx>

You can also request one by calling OEBB member services at 888-469-6322. You can mail or fax the completed form to OEBB using the information provided on the form.

Q: What if I have other questions or need help with the enrollment form?

A: You can contact OEBB Member Services:

By Phone:
1-888-469-6322

By Email:
oebb.benefits@oregon.gov

Staff are available to assist you Monday – Friday, 8:00 a.m. to 5:00 p.m.

Q: What happens if I pay my premiums late?

A: Coverage will be terminated back to the last day of the last fully paid month. Once coverage is terminated due to late or nonpayment, it cannot be reinstated.

Q: What if I no longer want a specific coverage (for instance, dental) and do not to pay the premium for it?

A: You can only cancel coverage during an Open Enrollment Period or within 31 days of a Qualified Status Change. Discontinuing payment for any portion of the monthly premiums mid-year will result in termination of all coverages through OEBB due to insufficient payment.

Q: What happens if my payment is returned for Non-Sufficient Funds (NSF)?

A: This is considered nonpayment and coverage will be terminated.

Q: What happens if I overpaid my premiums and want a refund?

A: If you do not request a refund, the overpayment will be held by OEGB and applied to future premiums as they become due. Your monthly statement will reflect your current balance, payments applied, and premium due, if any. To request a refund, contact OEGB Member Services:

By Phone:
1-888-469-6322

By Email:
oebb.benefits@oregon.gov

NOTE: Unless your coverage has been terminated, a processing fee will be assessed for refunds under \$100.00. If coverage has terminated, any excess premiums paid will be returned to you without additional fees.

Q: Will I receive an invoice each month?

A: Yes, OEGB will email you an invoice on the 15th of each month. The due date and amount due will be shown on the invoice.

Q: What if I don't have an email address?

A: Indicate on the ACH Debit form that you do not have an email address. Your monthly invoice will be mailed to the mailing address OEGB has on file for you.

Q: Can I make one lump payment to cover an entire year?

A: Advance payments may be made only within the same Plan Year. Please call OEGB Member Services at 1-888-469-6322 to make these arrangements.



Self-Pay Early Retiree (SPER) Enrollment Form

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

Use this form for your initial transition to Self-Pay Early Retiree (SPER) status.
Update your benefits within 31 days of experiencing one of the status changes listed in Section 1 below.

What type of Early Retiree are you?

- TYPE A — Active employee becoming SPER (no employer contributions/stipend)
 TYPE B — Early retiree with employer contribution/stipend becoming SPER (no employer contributions/stipend).

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 OEGB benefit plans* Remove one or more dependents*(Section 4 must be completed)

*** Warning:** If coverage is canceled, it cannot be added back without experiencing a qualifying life event. See the QSC Matrix for details.

SPER information

Last name	First name	Middle
E number or Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (<i>mm/dd/yyyy</i>)
Primary phone number	Cell phone number	
May OEGB send text messages to this number? Standard text message and data rates apply.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Address	<input type="checkbox"/> Check if new address	Apartment or space#
City	State	ZIP
County	Email	
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

*** Warning:** All SPERs and dependents of SPERs lose eligibility for OEGB plans on the day they become eligible for Medicare due to age 65 or disability (regardless of whether you enroll in Medicare coverage). Notify OEGB immediately if you or your dependent is or becomes eligible for Medicare. If coverage is canceled for you or a dependent it cannot be added back at a future date without a qualifying event. See QSC Matrix for details.

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, OEGB is requesting Ethnicity, Race and Primary Race information for all SPER'S 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 OEGB 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, OEGB may consider your omission an intentional misrepresentation of a material fact, for which OEGB may terminate the dependent's coverage effective the first of the month after eligibility was lost.

Attach additional sheets if necessary

Dependent A		<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Remove dependent	Remove: <input type="checkbox"/> Medical	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental
Relationship to SPER:		<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	<input type="checkbox"/> Child		
Gender:	Date of birth: (mm/dd/yyyy)	Social Security, HICN, or Tax ID Number:		Medicare eligible?		
<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Last name:		First name:		Middle:		
Address (if different from SPER address):				City:	State:	ZIP:
Ethnicity (Select one):		Race (Select at least one. If selecting more than one, circle one as primary):				
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino		<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/> Other				
<input type="checkbox"/> Refused <input type="checkbox"/> Unknown		<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander				
Dependent B		<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Remove dependent	Remove: <input type="checkbox"/> Medical	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental
Relationship to SPER:		<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	<input type="checkbox"/> Child		
Gender:	Date of birth: (mm/dd/yyyy)	Social Security, HICN, or Tax ID Number:		Medicare eligible?		
<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Last name:		First name:		Middle:		
Address (if different from SPER address):				City:	State:	ZIP:
Ethnicity (Select one):		Race (Select at least one. If selecting more than one, circle one as primary):				
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino		<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/> Other				
<input type="checkbox"/> Refused <input type="checkbox"/> Unknown		<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander				

Dependent C	<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Remove dependent	Remove: <input type="checkbox"/> Medical	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental
Relationship to SPER:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	<input type="checkbox"/> Child		
Gender:	Date of birth: (mm/dd/yyyy)	Social Security, HICN, or Tax ID Number:	Medicare eligible?		
<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Last name:	First name:	Middle:			
Address (if different from SPER address):		City:	State:	ZIP:	
Ethnicity (Select one):		Race (Select at least one. If selecting more than one, circle one as primary):			
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Latino		<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/> Other			
<input type="checkbox"/> Refused <input type="checkbox"/> Unknown		<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			

Medical, Vision, or Dental 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: _____

Vision

You may not change to a different vision plan. You may keep your current plan by leaving this blank or check Cancel Vision the box to cancel vision coverage.

Dental

You may not change to a different dental plan. You may keep your current plan by leaving this blank or check Cancel Dental the box to cancel dental coverage.

Cancel optional plans

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

Plan offering and availability is determined by your previous employer. Contact OEGB for coverage information and to find out which optional plans are available to you.

Things to consider:

1. Your previous employer may have automatically enrolled you in a coverage amount for basic life insurance and/or basic AD&D, if applicable.
2. 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 Employee Life in order to be enrolled in Optional Spouse/Domestic Partner Optional Life or Child Life.

Employee (SPER) Optional Life Insurance Cancel Coverage

Spouse/Domestic Partner Optional Life Insurance Cancel Coverage

Child(ren) Optional Life Insurance Cancel Coverage

Employee (SPER) Optional AD&D (Accidental Death & Dismemberment) Cancel Coverage

Spouse/Domestic Partner Optional AD&D Cancel Coverage

Child(ren) Optional AD&D Cancel Coverage

Other group coverage

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

<input type="checkbox"/> I do not have other group medical coverage <i>Skip to next section</i>		<input type="checkbox"/> I do have other group medical coverage <i>Complete this section</i>	
Carrier	Policy number	Group number	
Primary Policy Holder	Employer	Effective Date (mm/dd/yyyy)	

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

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

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

SPER signature and authorization

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

<http://www.oregon.gov/oha/OEBA/Pages/QSC-Matrix.aspx>

I have read the benefit materials and I understand the limitations and qualifications of the OEBA 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 OEBA 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 OEBA 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.

SPER signature

Date

Submit your completed form to:

By mail: OEBA

Attn: SPER Enrollment
500 Summer Street NE, E-88
Salem, OR 97301-1063

By fax: 503-378-5832



SPER Dental Only Open Enrollment Form

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

Early Retiree information

Last name	First name	Middle
E number or Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy)
Primary phone number	Cell phone number	Medicare eligible?*
		<input type="checkbox"/> Yes <input type="checkbox"/> No
May OEGB send text messages to this number? Standard text message and data rates apply.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Address	<input type="checkbox"/> Check if new address	Apartment or space#
City	State	ZIP
		County
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"/> White	<input type="checkbox"/> Other	<input type="checkbox"/> Refused
		<input type="checkbox"/> Native Hawaiian/Other Pacific Islander
		<input type="checkbox"/> Unknown

*** Warning! – All SPERs and dependents of SPERs lose eligibility for OEGB plans on the day they become eligible for Medicare due to age 65 or disability. Notify OEGB immediately if you or your dependent is eligible for Medicare, regardless of whether you enroll in Medicare coverage. If dropping coverage for you or a dependent it cannot be added back at a future date without a qualifying event. See QSC Matrix for details.**

Dental plan selection

Dental

Medical plan selection: _____ Cancel Dental

Write in plan selection.

SPER signature and authorization

I declare the dependents listed above and I are eligible for the coverages requested per OEGB 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 OEGB 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 experience a QSC; then I am subject to the restrictions of the OEGB QSCs. I have reviewed and understand the Qualified Status Change (QSC) Matrix which can be found 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. 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 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.

SPER signature

Date

Submit this form to OEGB by September 15, 2018

By mail: OEGB

Attn: SPER Enrollment

500 Summer Street NE, E-88

Salem, OR 97301-1063

By fax: 503-378-5832



ACH Debit Authorization SPER (Self-Pay Early Retiree)

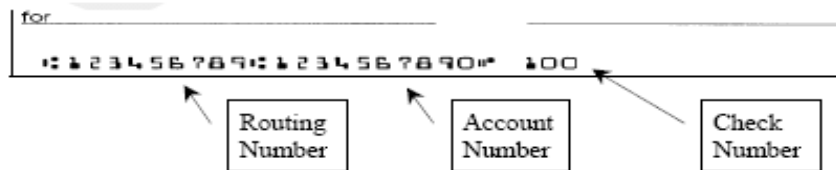
Use this form to authorize OEGB to withdraw premiums from your bank account each month. This authorization will remain in effect until revoked in writing, or until superseded by another form submitted at a later date. Should your premium amount change, the amount withdrawn will change accordingly without need for a new authorization.

If your banking information changes, submit another form with your new account information to maintain timely premium payments.

If you have questions or concerns, please call OEGB at (888) 469-6322

Frequently Asked Questions: ACH Debits

Where can I find my routing transit and account numbers on my check?



What is an ACH Debit Authorization?

The "ACH" stands for Automated Clearing House. ACH is an electronic payment network used by individuals, businesses, financial institutions and government organizations. Electronic ACH payments provide more efficient cash management capabilities and lower costs than traditional paper payments.

What am I authorizing OEGB to do?

By completing and signing this ACH Debit Authorization form, you give consent to OEGB to "auto-deduct" monthly insurance premiums directly from your account. To establish this recurring monthly transaction, you must complete this form and attach a VOIDED check to the address indicated above.

Do I need to fill out this form each plan year?

No. OEGB will continue to debit your account as long as you are eligible for OEGB benefits.

What is an international ACH determination?

Generally not applicable. This only applies if you have payment instructions to transfer funds from a Non-US Financial Institution to a US Financial Institution explicitly for funding of this debit transaction.

When will funds be withdrawn from my account?

Funds will be withdrawn for your monthly premiums directly from your checking or savings account on the 2nd business day of each month.



ACH Debit Authorization SPER (Self-Pay Early Retiree)

OEBB Use Only	
Approved by	_____
Date Approved	_____
Effective Date	_____

1. SPER Information

E Number				Date of Birth (mm-dd-yyyy)		
Last Name			First Name			MI
Address					Apt#	
City		State	Zip	County		
Personal Email			Home Phone		Mobile Phone	

2. Account Information

<input type="checkbox"/> New banking information <input type="checkbox"/> Update to existing banking information			Effective Date		
<input type="checkbox"/> Personal Account <input type="checkbox"/> Business Account		<input type="checkbox"/> Checking <input type="checkbox"/> Savings			
Financial Institution Name			Account Holder Name		
A VOIDED CHECK MUST BE ATTACHED If you do not have checks, please contact your financial institution to provide a letter verifying your account. Deposit slips are not sufficient.					
Nine-digit Routing Transit Number			Account Number (Show the number exactly as written including necessary spaces, zeros, or dashes.)		
International ACH Determination (More information is provided on the first page.)					
<input type="checkbox"/> I have payment instructions in place with a non-US Financial Institution to transfer funds to my US Financial Institution identified above for the specific purpose of funding this recurring debit transaction.					

3. Authorization

I hereby authorize OEBB to withdraw funds only from the above account at the financial institution indicated. I acknowledge that the origination of ACH transactions to my account must comply with the provision of Oregon and U.S. law.

_____ Date _____
Signature of Account Holder

How to Revoke Your Authorization

This authorization is to remain in full force and effect **until the Oregon Educators Benefit Board has received written notification from me of its termination**, in such time and manner as to afford OEBB and my financial institution a reasonable opportunity to act on it.

Send the completed form and a voided check to: OEBB, Financial Services 500 Summer Street NE, E-88 Salem, OR 97301-1063	Or by fax: 503-378-5832
--	--------------------------------



SPER Change of Address

OEBB Use Only

Approved by _____

Date Approved _____

Effective Date _____

Use this form to notify OEBB of changes to your address.
Please allow 7-10 business days for your address to be updated.

Self-Pay Early Retiree (SPER) Name:

E Number

Effective Date of Address Change

Old Address

Residence Address

City, State, Zip

Mailing Address (If Different)

City, State, Zip

Primary Phone

Cell Phone

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

Email

New Address

Residence Address

City, State, Zip

Mailing Address (If Different)

City, State, Zip

Primary Phone

Cell Phone

Email

SPER Signature

Date

Submit this form to OEBB:

By Mail:
OEBB
Attn: SPER Enrollment
500 Summer Street NE, E-88
Salem, OR 97301-1063

By Fax:
503-378-5832

By Email:
oebb.benefits@state.or.us