



# 2026 Open Enrollment Health Insurance Enrollment/Waiver/Change Form

Employee Information							
<b>Employee Name</b>		<b>Date of Birth</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		<b>Social Security Number</b>	
<b>Mailing Address</b> <input type="checkbox"/> Please check if this is a new address.			<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Phone Number</b>	
Health Insurance Enrollment or Waiver						Date of Event (hire date; birth; etc)	
<input type="checkbox"/> I elect to waive enrollment in all health insurance coverage. I have other health insurance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I elect the opt-out incentive and waive enrollment in all health insurance coverage. *Opt-out incentive waiver form and proof of other qualifying coverage is required to receive incentive funds						01/01/2026	
<b>Medical Plan Options</b>		<b>Vision Plan Options</b>		<b>Dental Plan Options</b>			
<input type="checkbox"/> Kaiser Permanente HMO <input type="checkbox"/> Cigna PPO OAP <input type="checkbox"/> Cigna HDHP + HSA (HSA election form) (IAFF and SPEU HRAVEBA contribution)		<input type="checkbox"/> Cigna Vision <input type="checkbox"/> I elect to waive vision coverage		<input type="checkbox"/> Moda/Delta Dental Traditional Dental <input type="checkbox"/> Moda/Delta Dental Incentive Dental (Restrictions apply) <input type="checkbox"/> Willamette Dental <input type="checkbox"/> I elect to waive dental coverage			
Enrollment Changes (This form must be submitted by the deadline listed below, or you must wait until the next open enrollment period.)							
<input type="checkbox"/> <b>New Enrollment*</b> <input type="checkbox"/> New hire or rehire <input type="checkbox"/> Job status change <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Other: _____		<input type="checkbox"/> <b>Add Dependent*</b> <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of other insurance <input type="checkbox"/> Other: _____		<input type="checkbox"/> <b>Cancel Dependent*</b> <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> New other insurance <input type="checkbox"/> Other: _____		<input type="checkbox"/> <b>Open Enrollment*</b> <input type="checkbox"/> Change medical plan <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change dental plan <input type="checkbox"/> New Waiver <input type="checkbox"/> Add or cancel vision plan <input type="checkbox"/> Other: _____ <input type="checkbox"/> Add Dependent <input type="checkbox"/> Cancel Dependent	
*Form must be submitted within <b>30 days</b> of event.		*Form must be submitted within <b>30 days</b> of event		*Form must be submitted within <b>30 days</b> of event.		*Form must be submitted before end of open enrollment.	
* Documentation of relationship and event must be submitted, such as a birth certificate, marriage certificate, divorce decree, adoption papers, proof of coverage loss, etc.							
Dependent Information Proof of Dependent Documentation is required for all dependents such as marriage license, child birth certificate, etc							
Coverage Election	Relationship (Domestic partner requires either registration or affidavit; imputed tax may apply)	Gender	Dependent Legal Name First and Last (Must match name on Social Security card)	Social Security # (Required)	Date of Birth	Disabled Child age 26+ (If yes, complete Disabled Dependent Certification form)	Other Insurance (If yes, complete Health Insurance Coordination of Benefits form)
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female				N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Partner's Child	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Partner's Child	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Partner's Child	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Partner's Child	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Partner's Child	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber Acknowledgement and Signature – Your signature is required before this enrollment form will be processed.							
<p>I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents. Health information requested or disclosed may be related to treatment or services performed by a physician, dentist, pharmacist or other physical or behavioral health care practitioner, clinic, hospital, long term care or other medical facility, or an insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding HIV/AIDS, psychotherapy notes, alcohol/drug and genetic testing. A separate authorization will be used for information related to these health conditions. I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Summary Plan Document. If requested, I will supply documentation of proof of my dependent relationship within 30 days of the request. I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any dependents. I acknowledge that my enrollment will be delayed if all fields are not filled out entirely. I acknowledge that my payroll deduction (if any) will be withheld pre-tax and understand this may reduce payments for my Social Security account. I authorize the City of Salem to automatically increase or decrease the amount deducted from my salary to reflect changes in premium rates. Failure to return the Coordination of Benefits form may result in a denial of claims payment until the form is received.</p>							
<b>Employee Signature:</b> _____				<b>Date:</b> _____			
Employer Use Only							
<b>Employee #:</b>	<b>Effective Date:</b> 01/01/2026	<input type="checkbox"/> Cigna	Branch#:	<b>Division:</b> <input type="checkbox"/> AFSCME (03 or 10) <input type="checkbox"/> IAFF/BC (02, 32, 22) <input type="checkbox"/> Unrepresented _____ <input type="checkbox"/> SCABU (30) <input type="checkbox"/> PCEA (12) <input type="checkbox"/> SPEU (01)		<b>Coverage Tier:</b> <input type="checkbox"/> EMP <input type="checkbox"/> E+C <input type="checkbox"/> E+S or DP <input type="checkbox"/> E+F	
<input type="checkbox"/> COBRA notice to BHS (if applicable)	<input type="checkbox"/> Tracking List	<input type="checkbox"/> Kaiser	Billing Unit:	Subgroup:	<b>Documentation received:</b> <input type="checkbox"/> Birth certificate <input type="checkbox"/> Marriage certificate <input type="checkbox"/> Court paperwork <input type="checkbox"/> Divorce decree <input type="checkbox"/> Tax Return <input type="checkbox"/> DP Registration or Affidavit; tax form <input type="checkbox"/> Other: _____		
		<input type="checkbox"/> Moda	Subgroup:	Class:	<input type="checkbox"/> Tier change Effective		
		<input type="checkbox"/> WDG	<input type="checkbox"/> HDHP HRAVEBA and B009				
		<input type="checkbox"/> Oracle FIMS	<input type="checkbox"/> Oracle ACA				
HR Representative signature _____ Date _____							