CITY OF Salem AT YOUR SERVICE

Health Insurance Enrollment/Waiver/Change Form

Subscriber Information

Employee Name	Date of Birth	Gender	Marital Status		Social Security Number
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner		
Mailing Address ☐ **Please check if this is a new address.**		**City**	**State**	**Zip Code**	**Phone Number**

Health Insurance Enrollment or Waiver

Date of Event

☐ I elect to waive enrollment in all health insurance coverage. I have other health insurance ☐ Yes ☐ No
☐ I elect the opt-out incentive and waive enrollment in all health insurance coverage. (AFSCME, PCEA, SPEU, Unrepresented)
*Opt-out incentive waiver form and proof of other qualifying coverage is required to receive incentive funds

Medical Plan Options	Vision Plan Options	Dental Plan Options
☐ Kaiser Permanente HMO ☐ EBMS PPO ☐ EBMS HDHP + HSA (HSA election form required)	☐ EBMS $250 Vision – (PCEA and SPEU only) ☐ EBMS $500 Vision – (All other groups) ☐ EBMS Traditional Vision (Some restrictions apply) ☐ I elect to waive vision coverage	☐ Moda Traditional Dental ☐ Moda Incentive Dental (Some restrictions apply) ☐ Willamette Dental (AFSCME, SCABU, IAFF, Unrepresented) ☐ 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.)

☐ **New Enrollment***	☐ **Add Dependent***	☐ **Cancel Dependent***	☐ **Open Enrollment***
☐ New hire ☐ Rehire ☐ Loss of coverage ☐ Other: ___________	☐ Birth ☐ Marriage ☐ Loss of coverage ☐ Other: ___________	☐ Divorce ☐ Death ☐ Ineligible dependent ☐ Other: ___________	☐ Change medical plan ☐ New Enrollment ☐ Change dental plan ☐ New Waiver ☐ Change vision plan ☐ Other: ___________ ☐ Add Dependent ☐ Cancel Dependent
***Form must be submitted within 30 days of event.**	***Form must be submitted within 60 days of event**	*** Form must be submitted within 60 days of event.**	***Form must be submitted before end of open enrollment.**

*** Documentation of event must be submitted, such as a birth certificate, marriage license, divorce decree, adoption papers, proof of coverage loss, etc.**

Dependent Information Proof of Dependent Documentation is required for all dependents such as marriage license, birth certificate, tax return, court paperwork

Coverage Election	Relationship	Gender	Dependent Legal Name First and Last (Must match name on Social Security card)	Social Security # (Required)	Date of Birth	Disabled Child (If yes, complete Disabled Dependent Certification form	Other Insurance (If yes, complete Health Insurance Coordination of Benefits form)
☐ Add ☐ Cancel	☐ Spouse ☐ Same-Sex Partner	☐ Male ☐ Female				N/A	☐ Yes ☐ No
☐ Add ☐ Cancel	☐ Child ☐ Stepchild ☐ Partner's Child	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
☐ Add ☐ Cancel	☐ Child ☐ Stepchild ☐ Partner's Child	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
☐ Add ☐ Cancel	☐ Child ☐ Stepchild ☐ Partner's Child	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
☐ Add ☐ Cancel	☐ Child ☐ Stepchild ☐ Partner's Child	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
☐ Add ☐ Cancel	☐ Child ☐ Stepchild ☐ Partner's Child	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No

Subscriber Acknowledgement and Signature – Your signature is required before this enrollment form will be processed.

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.

Employee Signature: ____ **Date:** ______________________________

Employer Use Only

Employee #:	**Effective Date:**	☐ **EBMS**	Division Code: conf#:	**Division:** ☐ AFSCME (03) ☐ IAFF/BC (02 or 32) ☐ Unrepresented ____ ☐ SCABU (30) ☐ PCEA (12) ☐ SPEU (01)	**Coverage Tier:** ☐ EMP ☐ E+C ☐ E+S ☐ E+F ☐ Tier change Effective __________	**Documentation received:** Yes ☐ No ☐ Follow-up required Documentation: ☐ Birth certificate ☐ Marriage license ☐ Court paperwork ☐ Divorce decree ☐ Tax Return ☐ Other: ______________
		☐ **Kaiser**	Billing Unit: Subgroup:			
☐ COBRA notice to BHS (If applicable)	☐ Tracking List	☐ **Moda**	Subgroup: Class:			
		☐ **WDG**	EBMS system			
___________ HR Representative signature	___________ Date	☐ **Oracle FIMS** ☐ **Oracle ACA**				