

Health Insurance Enrollment/Waiver/Change Form

Subscriber Information							
Employee Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Social Security Number	
Mailing Address <input type="checkbox"/> Please check if this is a new address.			City	State	Zip Code	Phone Number	
Health Insurance Enrollment or Waiver						Date of Event	
<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. (AFSCME, PCEA, Unrepresented only) *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			
<input type="checkbox"/> Kaiser Permanente HMO <input type="checkbox"/> EBMS PPO <input type="checkbox"/> EBMS HDHP + HSA (HSA election form required)		<input type="checkbox"/> EBMS \$250 Vision – (PCEA and SPEU only) <input type="checkbox"/> EBMS \$500 Vision – (All other groups) <input type="checkbox"/> EBMS Traditional Vision (Some restrictions apply) <input type="checkbox"/> I elect to waive vision coverage		<input type="checkbox"/> Moda Traditional Dental <input type="checkbox"/> Moda Incentive Dental (Some restrictions apply) <input type="checkbox"/> Willamette Dental (AFSCME, SCABU, IAFF, Unrepresented) <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"/> New Enrollment* <input type="checkbox"/> New hire <input type="checkbox"/> Rehire <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Other: _____		<input type="checkbox"/> Add Dependent* <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Other: _____		<input type="checkbox"/> Cancel Dependent* <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Ineligible dependent <input type="checkbox"/> Other: _____		<input type="checkbox"/> Open Enrollment* <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"/> Change vision plan <input type="checkbox"/> Other: _____ <input type="checkbox"/> Add Dependent <input type="checkbox"/> Cancel Dependent	
*Form must be submitted within 30 days of event.		*Form must be submitted within 30 days of event		*Form must be submitted within 30 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 <small>(Must match name on Social Security card)</small>	Social Security # <small>(Required)</small>	Date of Birth	Disabled Child <small>(If yes, complete Disabled Dependent Certification form)</small>	Other Insurance <small>(If yes, complete Health Insurance Coordination of Benefits form)</small>
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Spouse <input type="checkbox"/> Same-Sex 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.							
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:	<input type="checkbox"/> EBMS <input type="checkbox"/> Kaiser	Division Code: _____ conf#: _____	Division: <input type="checkbox"/> AFSCME (03) <input type="checkbox"/> IAFF/BC (02 or 32) <input type="checkbox"/> Unrepresented _____ <input type="checkbox"/> SCABU (30) <input type="checkbox"/> PCEA (12) <input type="checkbox"/> SPEU (01)	Coverage Tier: <input type="checkbox"/> EMP <input type="checkbox"/> E+C <input type="checkbox"/> E+S <input type="checkbox"/> E+F	Documentation received: Yes <input type="checkbox"/> No <input type="checkbox"/> Follow-up required Documentation: <input type="checkbox"/> Birth certificate <input type="checkbox"/> Marriage license <input type="checkbox"/> Court paperwork <input type="checkbox"/> Divorce decree <input type="checkbox"/> Tax Return <input type="checkbox"/> Other: _____	
<input type="checkbox"/> COBRA notice to BHS (if applicable)	<input type="checkbox"/> Tracking List	<input type="checkbox"/> Moda	Billing Unit: _____ Subgroup: _____	<input type="checkbox"/> WDG	<input type="checkbox"/> Tier change Effective		
HR Representative signature _____ Date _____		<input type="checkbox"/> Oracle FIMS <input type="checkbox"/> Oracle ACA	Subgroup: _____ Class: _____	EBMS system			