Lane Community College

# 2014-15 Insurance Enrollment Form (PT Faculty)

## 1. Employee Information

| Social Security Number | L# |
|---|---|
| | |

| Last Name | First Name | Date of Birth | Gender |
|---|---|---|---|
| | | | ☐ M ☐ F |

Ethnicity (select one): ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race (select one or more, circle one as primary): ☐ Asian ☐ Black/Afrian American ☐ American Indian/Alaska Native ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Refused ☐ Unknown

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Work Phone | Personal Email | Work Email |
|---|---|---|---|
| | | | |

## 2. Dependent Information

Attach separate sheet if necessary.

**Relationship Codes** ("Rel. Code" below – Please indicate one per dependent.)
**SP**=Spouse, **CH**=Employee and/or Spouse's child, **DD**=Disabled Dependent, **DP**=Domestic Partner*, **DP CH**=Domestic Partner's Child*

**Ethnicity Codes** (Please indicate one per dependent below.)
**1**=Hispanic, **2**=Non-Hispanic/Non-Latino, **3**=Refused, **4**=Unknown

**Race Codes** (Please indicate one or more per dependent below. If more than one, please indicate one primary race in the next column.)
**1**=Asian, **2**=Black/African American, **3**=American Indian/Alaskan Native, **4**=Native Hawaiian/Other Pacific Islander, **5**=White, **6**=Other, **7**=Refused, **8**=Unknown

Due to Federal Health Care Reform, OEBB is requesting Ethnicity, Race and Primary Race information for all members and dependents. Please indicate one ethnicity code for each dependent and at least one race code for each dependent. If indicating more than one race code for a dependent, please also indicate in the next column which one of those race codes is the dependent's primary race.

| Last Name | First Name | Date of Birth | Rel Code | Gender M F | Ethnicity Code | Race Code(s) | Primary Race |
|---|---|---|---|---|---|---|---|
| | | | | ☐ ☐ | | | |
| | | | | ☐ ☐ | | | |
| | | | | ☐ ☐ | | | |
| | | | | ☐ ☐ | | | |
| | | | | ☐ ☐ | | | |

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 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, OEBB may consider your omission as an intentional misrepresentation of a material fact, for which OEBB may terminate the dependent's coverage effective the first of the month after eligibility was lost.

## 3. Medical, Dental and Vision Plan Selection

Indicate a selection for each plan type.

| | | |
|---|---|---|
| Medical Benefit Plan Selection (includes pharmacy benefit) | ☐ ODS Medical Plan A<br>☐ ODS Medical Plan B<br>☐ ODS Medical Plan C<br>☐ ODS Medical Plan E<br>☐ ODS Medical Plan G | ☐ Decline Medical<br>Explanation (required if declining):<br>_____<br>_____ |
| Dental Benefit Plan Selection | ☐ ODS Dental Plan 1<br>☐ ODS Dental Plan 4<br>☐ Willamette Dental Plan 8 | ☐ Decline Dental |
| Vision Benefit Plan Selection | ☐ ODS Vision Plan 4 | ☐ Decline Vision |

Notice: If you waive benefit coverage(s) now, you may be subject to waiting period restrictions at a later date.

## 4. Tobacco Usage

| | Please select one of the following: | Please select one of the following: |
|---|---|---|
| Beginning with plan selections for the 2013-14 plan year, OEBB 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 beginning October 1, 2014. | ☐ I currently use tobacco products.<br>☐ I have not used tobacco products in the past 12 months.<br>☐ I have never used tobacco products. | ☐ I do not currently have a spouse or domestic partner.<br>☐ My spouse/domestic partner currently uses tobacco products.<br>☐ My spouse/partner has not used tobacco products in the past 12 months.<br>☐ My spouse/domestic partner has never used tobacco products. |

## 5. Medicare Eligibility

| | The following individuals are eligible for Medicare due to age or disability: | | |
|---|---|---|---|
| ☐ No one listed on this form is eligible for Medicare. | ☐ Self | ☐ Spouse or Domestic Partner | ☐ Dependent Child |
| | | Name: | Name: |
| | | SSN: | SSN: |

## 6. Voluntary Long Term Care

All employee coverage elections above the guarantee issue amount and/or beyond the guarantee issue period must be medically underwritten. Additionally, all spouse/partner coverage must be medically underwritten. Please contact Human Resources to obtain the application for this process.

| ☐ Employee Coverage: | ☐ Spouse/Domestic Partner Coverage: |
|---|---|
| Monthly Coverage (in $1000 increments): $_____ | Monthly Coverage (in $1000 increments): $_____ |
| Duration (circle one): ☐3-Years ☐6-Years ☐Lifetime | Duration (circle one): ☐3-Years ☐6-Years ☐Lifetime |
| Simple Inflation (circle one): ☐with ☐without | Simple Inflation (circle one): ☐with ☐without |
| Total Home Care (circle one): ☐with ☐without | Total Home Care (circle one): ☐with ☐without |

## 7. Voluntary Life Insurance

All coverage elections above the guarantee issue amount and/or beyond the guarantee issue period must be medically underwritten. Please mark the box for all coverage(s) you are applying for. By selecting "no", an application for coverage at a later date may require further medical information and/or physical exam, which may be at the member's own expense.

| Voluntary Employee Coverage | Voluntary Spouse/Domestic Partner Coverage |
|---|---|
| ☐ Life Only (in $10,000 increments): $_____ | ☐ Life Only (in $10,000 increments): $_____ |
| ☐ Life & AD&D (in $10,000 increments): $_____ | ☐ Life & AD&D (in $10,000 increments): $_____ |
| *$100,000 Guarantee Issue* | *$30,000 Guarantee Issue* |
| *$500,000 Maximum Coverage* | *$500,000 Maximum Coverage* |
| Employees must elect coverage in order to elect spouse/partner and/or dependent coverage. Total employee amount must be equal to or greater than requested amount for spouse/partner coverage. | Voluntary Dependent Child Coverage |
| | ☐ Life Only (in $2,000 increments): $_____ |
| | ☐ Life & AD&D (in $2,000 increments): $_____ |
| | *$10,000 Maximum Coverage* |

## Beneficiary Information

A contingent beneficiary will receive benefits only if the primary beneficiary does not survive you.

| Name and Address | Relationship | Primary or Contingent | | Percentage |
|---|---|---|---|---|
| | | ☐ | ☐ | % |
| | | ☐ | ☐ | % |
| | | ☐ | ☐ | % |
| | | ☐ | ☐ | % |

## 8. Healthy Futures Participation

☐ YES – I want to participate in the Health Futures program.

☐ NO – I do not want to participate in the Healthy Futures program.

1. I understand that I and my spouse or domestic partner, if applicable, have until March 31, 2015 to make a decision about participating in Healthy Futures and we can either enter the MyOEBB Member Module or contact our educational entity until the above date to agree to participate in Healthy Futures.
2. I understand that if I agree to participate in Healthy Futures I will need to complete the Health Assessment for my medical plan, Moda Health, and I will complete the Health Assessment by May 31, 2015.
3. I understand that if I agree to participate in Healthy Futures I will need to complete two wellness activities by August 15, 2015.
4. I understand that if my spouse or domestic partner, if applicable, agrees to participate in Healthy Futures they will independently have to complete the Health Assessment for their medical plan, Moda Health, by May 31, 2015.
5. I understand that if my spouse or domestic partner, if applicable, agrees to participate in Healthy Futures they will independently need to complete two wellness activities by August 15, 2015.
6. I and my spouse or domestic partner (if applicable) will complete two wellness activities before August 15, 2015, as follows:
   a. If my/their health assessment indicates that my/their weight is a risk to my/their health, or if my/their BMI exceeds 27 or my/their waist circumference exceeds a certain number of inches (35 inches for women unless pregnant or within 24 months after giving birth, or 40 inches for men), one of my/their wellness activities will address that risk. Some examples of wellness activities to address this risk are:
      - participate in Weight Watchers
      - nutritional counseling by a registered dietician
      - a program of physical activity
      - an assessment and action plan developed by my health care provider
      - participation in Healthy TEAM Healthy U, a team-based health engagement program sponsored by OEBB

   b. If my/their health assessment indicates that tobacco use is a risk to my/their health, one of my/their wellness activities will address that risk. Some examples of wellness activities that address this risk are:
      - participate in a tobacco cessation program – either Quit for Life or another therapy recommended by my healthcare provider
      - work through the e-tools on your medical carrier's website on tobacco cessation
      - participation in Health TEAM U, a team-based health engagement program sponsored by OEBB

   c. If weight or tobacco are not health risks for me (or my spouse/domestic partner), I/they will take action to address other health risks identified in my assessment, or to maintain my current good health. Some examples include:
      - other online programs available through the carriers, like "Fit It In" through Moda Health
      - participate in a school employee wellness activity or a team-based/worksite-based health promotion program
      - participate in walking programs sponsored by associations or clubs, PTA, health clubs
      - e-lessons on topics of your choice (available on your medical carrier's website)
      - preventive services recommended for your age by the U.S. Preventive Services Taskforce (annual dental cleaning, mammogram, colonoscopy, etc.)
      - participation in Healthy TEAM Healthy U, a team-based health engagement program sponsored by OEBB
7. I understand that the actions listed above are just examples. There are many actions that support good health which will qualify.
8. I understand that if a licensed medical professional from Kaiser or Moda Health calls me about a diagnosed chronic condition or other illness based on information submitted by my healthcare provider, I will accept or return the call to learn about potential support services for managing my condition.
9. I understand that if a licensed medical professional from Moda Health calls my spouse or domestic partner, if applicable, about a diagnosed chronic condition or other illness based on information submitted by his or her healthcare provider, he or she will accept or return the call to learn about potential support services for managing their condition.

10. I will document the actions I take for Healthy Futures. My documentation will include dates of completing the Health Assessment and wellness activities, contacts with a case or disease manager and participation in program requirements, if applicable, for weight management or tobacco cessation.
11. My spouse or domestic partner, if applicable, will document the actions he or she takes for Healthy Futures. Their documentation will include dates of completing the Health Assessment and wellness activities, contacts with a case or disease manager and participation in program requirements, if applicable, for weight management or tobacco cessation.
12. I have informed my spouse or domestic partner that he or she must individually complete a Health Assessment by May 31, 2015, and two wellness activities by August 15, 2015.
13. I understand that I, and my spouse or domestic partner, if applicable, can request to have answers from my and my spouse or domestic partner's Health Assessment shared with my/their primary care provider with my/their approval.
14. I understand that if a medical condition or disability makes it unreasonably difficult for me or my spouse or domestic partner (if applicable) to achieve a standard described in 1 through 6 (above), or if attempting to do so is medically inadvisable, a reasonable alternative to the standard will be provided. I further understand that I may contact OEBB at 888-469-6322, and OEBB will work with me (and, if I wish, with my doctor) to find a reasonable alternative that is right for me in light of my health status.

I understand I will not have an incentivized medical deductible for the 2014-15 plan year if I or my spouse or domestic partner (if applicable) miss deadlines for agreeing to participate in Healthy Futures by March 31, 2015, completing the Health Assessment by May 31, 2015, and completing two wellness activities by August 15, 2015.

## 9. Employee Signature and Authorization

I declare the dependents listed above and I are eligible for the coverage(s) requested per OEBB 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 OEBB's eligibility requirements, or until I elect to change them subject to the provisions of OEBB'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 OEBB QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix at **http://www.oregon.gov/OHA/OEBB/docs/QSCMatrix.pdf**

I have read the benefit materials and I understand the limitations and qualifications of the OEBB 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 OEBB 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 OEBB 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