SB 551 Member Enrollment

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

Member information

Last name	First name	Middle
E number or Social Security Number	Gender ☐ M ☐ F ☐ Other	Date of birth *(mm/dd/yyyy)*
Home phone number	Work phone number	Cell phone number

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

Personal email	Work email

Address ☐ Check if new address — Apartment or space#

City — State — ZIP — County

Are you Medicare eligible? ☐ Yes ☐ No

Are you serving or did you ever serve in the military? ☐ Yes ☐ No

If "Yes," do you authorize OEBB to send your name and address to the Oregon Department of Veterans' Affairs (ODVA) for the purpose of receiving benefit information? ☐ Yes ☐ No

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

Race *(Select at least one. If selecting more than one, circle one as primary):*

☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Healthcare plan selections

Medical

Medical plan selection: _____

Write in plan selection.

If enrolled in a Moda medical plan, each covered individual must choose a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit if using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive the "non-coordinated" benefit if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level regardless of whether or not the individual has chosen a PCP 360 with Moda. A list of PCP 360 providers can be found at: https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml

Vision

Vision plan selection: _____

Write in plan selection *(Must be enrolled in Kaiser Medical to enroll in Kaiser Vision)*

Dental

Dental plan selection: _____

Write in plan selection.

Dental late enrollment penalty

I understand **if I decline dental coverage** when initially eligible or allow coverage to lapse, then choose to enroll at a future Open Enrollment period, any enrolled dependents and I will be subject to a 12-month waiting period, meaning only diagnostic and preventive care (*cleanings, x-rays, and exams*) will be covered for the first 12 months of dental coverage.

Employee signature _____ Date _____

Member signature and authorization

I understand that these benefit elections will remain in effect for as long as I continue to meet the SB 551 eligibility or participation requirements as determined by my selected Home Institution.

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: Division 80

I understand I have 31 days to notify my Home Institution of a Qualified Status Change (QSC) which affects eligibility. A full list of QSC's can be found at: http://www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx

I have read and understand OAR-Division 40 concerning Enrollment and can find this OAR at: Division 40

I have read the benefit materials and I understand the limitations and qualifications of the SB 551 benefits program.

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 SB 551 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.

Member signature _____ Date _____

Submit this form to your Community College for SB 551 Coverage:

DO NOT SUBMIT TO OEBB