CITY OF EUGENE COBRA/RETIREE HEALTH PLAN OPEN ENROLLMENT FORM

If you need additional information or have questions, contact the Employee Benefits Program at 541-682-5061
Return form to City of Eugene Employee Resource Center Benefits Program, 940 Willamette St, Suite 200, Eugene, OR 97401

SECTION A

Name (Last, First, Middle Initial)	**Union/Employee Unit** ☐ AFSCME ☐ EPEA ☐ IAFF ☐ IAFF-BC ☐ Non Rep ☐ IATSE			**Email Address (Optional)**
Mailing Address (Street or PO Box)	City	State	ZIP Code	**Home or Cell Phone Number**

ACTION (select all that apply):	**HEALTH PLAN OPTION:**
☐ Change Health Plan	☐ City Health Plan
☐ Add or Drop Dental/Vision	☐ City Managed Care Plan
☐ Add Dependent Name: _____	☐ City Hybrid Health Plan *(AFSCME-, IATSE- and Non-Represented ONLY)*
☐ Drop Dependent Name: _____	

COVERAGE OPTION:

☐ Option 1 Medical/Dental/Vision Coverage

☐ Option 2 Medical Only Coverage

NOTE: Continuation of Dental/Vision coverage, if eligible, is a decision made at the time of the Qualifying Event. Adding or deleting Dental/Vision coverage in the future can only take place during open enrollment periods.

Note: Retirees or their dependents that are eligible for Medicare may not enroll in City of Eugene Medical Coverage.

ELIGIBLE DEPENDENTS must meet the following conditions: legal spouse or registered or non-registered domestic partner; children who meet the definition of eligible dependents and are within the age limits specified in the policy(ies) or who have qualified from age 19 under provisions for incapacitated children. (Registered domestic partners are same-sex couples who have registered their partnership with the State of Oregon. Please complete a COE *Declaration of Domestic Partnership* form if adding a non-registered Domestic Partner.)

SECTION B **PLEASE COMPLETE THE FOLLOWING – *INCLUDE YOURSELF AND EACH OF YOUR ELIGIBLE DEPENDENTS TO RECEIVE COVERAGE UNDER YOUR PLAN***

Family Member Name (Last, First, Middle Initial)	**Relationship to COBRA/Retiree Subscriber**	**Gender**	**Date of Birth**	**Social Security Number (Required)**	**Covered Under Other Group Plan?**	**Living Out of Area?**	**If child lives with a different custodial parent or guardian, please list custodial parent or guardian name & address if known.**
COBRA/Retiree Subscriber	Self	☐ M ☐ F			Yes No Medical ☐ ☐ Dental ☐ ☐	☐ Yes	
Dependent - Spouse / Domestic Partner	☐ Spouse ☐ Registered DP ☐ Non-registered DP	☐ M ☐ F			Yes No Medical ☐ ☐ Dental ☐ ☐	☐ Yes	
Dependent		☐ M ☐ F			Yes No Medical ☐ ☐ Dental ☐ ☐	☐ Yes	☐ Yes
Dependent		☐ M ☐ F			Yes No Medical ☐ ☐ Dental ☐ ☐	☐ Yes	☐ Yes
Dependent		☐ M ☐ F			Yes No Medical ☐ ☐ Dental ☐ ☐	☐ Yes	☐ Yes

I hereby apply for insurance under the provisions of the group plan for which I am eligible and I understand and authorize the necessary payroll deductions, if any, for payment of my health plan coverage. I authorize the release of the information on this form to be used by the City of Eugene or any insurance company providing benefits under the plan(s) which is required to establish the validity of my claim for myself or my insured dependents.

_____ _____

Signature **Date**