CITY OF EUGENE COBRA/RETIREE HEALTH PLAN OPEN ENROLLMENT FORM

If you need additional information or have questions, contact Benefits Staff at 541-682-5061. Return form to City of Eugene Employee Resource Center Benefits Program, 940 Willamette St, Suite 200, Eugene, OR 97401, by fax to 541-650-3031, or via email to benefitsstaff@eugene-or.gov.

SECTION A

Name (Last, First, Middle Initial)	**Bargaining Unit -** ☐ AFSCME ☐EPEA ☐IAFF ☐IAFF-BC ☐Non-Rep ☐ IATSE			**Email Address (Optional)**
Mailing Address (Street or PO Box)	City	State	ZIP Code	**Preferred Phone Number**
ACTION (select all that apply): ☐ Change Health Plan ☐ Add or Drop Dental/Vision ☐ Add Dependent ☐ Drop Dependent Name of Dependent to Add/Drop _____	**HEALTH PLAN OPTION:** ☐ City Health Plan ☐ City Managed Care Plan ☐ City Hybrid Plan (AFSCME, IATSE, and Non-Rep ONLY)			
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. 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 or policies 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.**
		M	**F**			**Medical**	**Dental**		
COBRA/Retiree Subscriber	Self	☐	☐	____/____/____	_____-___-_____	☐	☐	☐ Yes	
Dependent – Spouse/Reg. DP/Non-Reg. DP		☐	☐	____/____/____	_____-___-_____	☐	☐	☐ Yes	
Dependent		☐	☐	____/____/____	_____-___-_____	☐	☐	☐ Yes	
Dependent		☐	☐	____/____/____	_____-___-_____	☐	☐	☐ 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**