CITY OF EUGENE HEALTH PLAN ENROLLMENT FORM

RESET FORM

If you need additional information or have questions, contact the Employee Benefits Program at 541-682-5062.
Return form to City of Eugene Risk Services Benefits Program, 940 Willamette St, Suite 200, Eugene, OR 97401.

SECTION A

Name (Last, First, Middle Initial)	**Employee Number**	☐ **Full-Time** ☐ **Part Time** **Hours per Week** ________	**Bargaining Unit** ☐ AFSCME ☐EPEA ☐ IAFF ☐ IAFF-BC ☐ Non Rep ☐ IATSE

Mailing Address (Street or PO Box)	City	State	ZIP Code	**Home Phone Number**	**Work Phone Number**	**Dept/Division**

REASON FOR CHANGE

☐ New Hire Initial Enrollment – Date of Hire ______________________
☐ Family Status Change - Date of Qualifying Event: ____________________
☐ Employment Status Change - Date Employment Changed: _________________
☐ Name Change – Previous Name: ________________________________
☐ Change at Open Enrollment

ACTION (Select all that apply)

☐ Change Plans
☐ Bargaining Unit Change
☐ Drop Dependent(s) ***(also complete Section B)*** Name of Dependent:(s): ________________________
☐ Add Dependent(s) ***(also complete Section B)*** Name of Dependent(s): ________________________
☐ Other Type of Action: ________________________________
➢ List Reason for Action: (marriage, divorce, overage child, full-time to part-time, DP eligible, birth, adoption, no premium change, etc.)

COMMENTS:

HEALTH PLAN OPTION:
☐**City Health Plan (PPO)** – You do not need to list your Primary Care Physician if you are enrolling in this plan.
☐ **City Managed Care Plan (POS)** - You must list your Primary Care Physician if you are enrolling in this plan.
☐ **City Hybrid Health Plan (POS)** – (IATSE and Non-Represented ONLY) You must list your Primary Care Physician if you are enrolling in this plan.

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 Employee	Gender	Date of Birth	Social Security Number (Required)	Covered Under Other Group Plan?	Full Name of Primary Care Physician (POS Plans Only)	Established Patient?	Living Out of Area?	Does child live with a different custodial parent or guardian? *If yes, list custodial parent or guardian name & address if known.*
Employee	Self	☐ M ☐ F			Medical ☐ Y ☐ N Dental ☐ Y ☐ N		☐ Yes ☐ No	☐ Yes	
Dependent - Spouse / Domestic Partner	☐ Spouse ☐ Registered DP ☐ Non-registered DP	☐ M ☐ F			Medical ☐ Y ☐ N Dental ☐ Y ☐ N		☐ Yes ☐ No	☐ Yes	
Dependent		☐ M ☐ F			Medical ☐ Y ☐ N Dental ☐ Y ☐ N		☐ Yes ☐ No	☐ Yes	☐ Yes
Dependent		☐ M ☐ F			Medical ☐ Y ☐ N Dental ☐ Y ☐ N		☐ Yes ☐ No	☐ Yes	☐ Yes
Dependent		☐ M ☐ F			Medical ☐ Y ☐ N Dental ☐ Y ☐ N		☐ Yes ☐ No	☐ Yes	☐ Yes
Dependent		☐ M ☐ F			Medical ☐ Y ☐ N Dental ☐ Y ☐ N		☐ Yes ☐ No	☐ 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.

____ ____________________
Employee Signature **Date**

Benefits Staff Use Only : Enrollment Date ____________ Deduction Begin Date ____________ ☐Pointer ☐No Pointer ☐PSoft ☐ ODS ☐ QE ☐ H/C Benefit Info By____________