2022 COBRA OPEN ENROLLMENT FORM

COBRA
Participants: IUOE

Type of Change: ☐ Add Dependent ☐ Remove Dependent ☐ Change Plans

Effective Date: January 1, 2022

1. COBRA Participant (please print) ☐ **Change of Address**	
Name (Last name, First Name)	Social Security Number:
Address, Street, City, State and Zip	Date of Birth:
Home/Cell Phone	Email Address

2. Choose One Medical Plan

- ☐ **Kaiser Medical**
- ☐ **Kaiser Maintenance Medical** (Kaiser Maintenance available to former part-time employees)
- ☐ **Cigna Preferred Medical**
- ☐ **Cigna Performance Medical**
- ☐ **Cigna Major Medical**

3. Choose One Dental Plan

- ☐ **Kaiser Dental**
- ☐ **Delta Dental**
- ☐ **Willamette Dental**

4: COBRA Participant Information				
COBRA Participant		DOB	Gender	Medical ☐ Dental ☐

5. List family members					
Name	SSN	Relationship	DOB	Gender	Medical ☐ Dental ☐
Name	SSN	Relationship	DOB		Medical ☐ Dental ☐
Name	SSN	Relationship	DOB		Medical ☐ Dental ☐
Name	SSN	Relationship	DOB		Medical ☐ Dental ☐

By signing below, I hereby certify the information furnished on this form is complete and accurate. I understand my premium payment will reflect the required premium for my election coverage.

I understand I am required to pay the appropriate premium in order to remain enrolled for coverage.

I have accurately described the relationship of each dependent to be enrolled on my plan. Enrollment of ineligible dependents can be considered fraud, and I may be held liable for benefits paid by the plan on an ineligible dependent.

I will report changes to my enrolled dependent's status immediately to the County Benefits Office.

I am responsible for notifying Multnomah County when I or my dependent(s) become Medicare eligible. I understand failure to report this information to Multnomah County within 45 days is considered fraud and may result in cancellation of my COBRA coverage.

I may not change my election until the next annual open enrollment period unless I experience a qualifying family status event that allows an enrollment change.

My signature authorizes any medical care institution, medical or dental, to furnish my health carrier with any information related to services or treatment of me or my dependents necessary for administering claims under my elected policy.

6. Signature

X_____ _____

COBRA Participant (Typing your name and attaching form to an email is allowable) **Date**

Return to Multnomah County Benefits Office by **November 17, 2021**

Email: employeee.benefits@multco.us
US Mail: Multnomah County COBRA
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Questions: 503-988-3477