Retiree Benefits Enrollment/Change Form

For Retirees
from: IUOE

Select: ☐ Retiree Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ End Enrollment ☐ Change Plans ☐ Dependent Only

1. Retiree Information: ☐ **Change of Address**

Name

Address, Street, City, State and Zip

Phone Number

Personal Email Address

2. Select one:

- ◯ **Kaiser Medical**
- ◯ **Kaiser Maintenance Medical**
- ◯ **Cigna Preferred Medical**
- ◯ **Cigna Performance Medical**
- ◯ **Cigna Major Medical**
- ◯ **No Medical Plan** (You cannot re-enroll)

3. Select one:

- ◯ **Kaiser Dental**
- ◯ **Delta Dental**
- ◯ **Willamette Dental**
- ◯ **No Dental Plan** (You cannot re-enroll)

4. Eligible dependents you want covered:

Name	SSN	Relationship	DOB	Gender	Medical	Dental
					☐	☐
					☐	☐
					☐	☐
					☐	☐

5. Reason for change: (i.e. divorce, marriage, Medicare eligible, etc.)

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 in 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 Retiree Health Plan coverage. Resulting overpayments of subsidy or claims will be recovered from retiree by the County.

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 and/or dental care institution 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.

X _____ _____

Retiree Signature **Date**

Electronic signature allowed.

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FAX: 503-988-6257
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