MULTNOMAH COUNTY - BENEFIT CHANGE FORM
PLAN YEAR - JANUARY 1 - DECEMBER 31

EMPLOYEE INFORMATION

SAP #	Employee Last Name	First Name	SS#	Birth Date

Street Address	Home Phone Number

City	State	Zip Code	Work Phone Number ext.	Gender

TYPE OF CHANGE - INDICATE WHAT YOU WANT TO DO

☐ Plan Change
☐ Add Dependent(s) to coverage
☐ Remove Dependent(s) from coverage

Required information

Name of removed dependent(s):
Reason for removing dependent:
Date dependent became ineligible:

☐ Opt into County coverage
☐ Opt Out of County coverage *(Attach proof of other coverage)*
☐ Other: _____

REASON FOR CHANGE - TELL US WHY YOU WANT TO MAKE THIS CHANGE

☐ Marriage or newly eligible domestic partner. *You must also attach an Affidavit of Marriage or Domestic Partnership.*
☐ Divorce/Termination of Domestic Partnership. *You must attach a Statement of Termination of Marriage/Domestic Partnership.*
☐ Birth, adoption, or placement of child pending adoption *(copies of legal adoption/placement documents required)*
☐ Dependent child no longer eligible - **please state reason** above *(overage, eligible for other coverage, etc.)*
☐ Significant change to, or loss of, health coverage *(Documentation required) :* _____
☐ County Employee employment status change (part-time to full-time or full-time to part-time)
☐ Other:

ENROLLMENT INFORMATION - LIST AND ALL FAMILY MEMBERS YOU WANT TO COVER
Employee plan choice applies to any dependent(s) enrolled in coverage

LIST DEPENDENTS BELOW using one of these Dependent Codes:

- ► A = Legal Spouse
- ► B = Domestic Partner
- ► C = Biological/Adopted Son/Daughter
- ► D = Stepson/Stepdaughter
- ► E = DomPtnr's Son/Daughter
- ► F = Court Appointed or child placed for adoption
- ► G = Grandchild*

Dep Code	Last Name	First Name	MI	Birth Date	SS#	Gender	Check Choice ✓ Medical	Dental

**If enrolling grandchild, please identify grandchild's natural parent:* _____
and complete a Grandchild Affidavit

Is your spouse/domestic partner a Multnomah County employee? ☐ Yes ☐ No

If yes - Please provide name of your spouse/domestic partner:

MEDICAL PLAN OPTIONS - CHOOSE ONE

- ☐ **KAISER 10/20 MEDICAL PLAN**
- ☐ **KAISER MAINTENANCE PLAN - Part-Time Employees Only**
- ☐ **MODA PPO 400 MEDICAL PLAN**
- ☐ **MODA MAJOR MEDICAL PLAN - Not available to full-time Local 88 employees**
- ☐ **OPT OUT OF MEDICAL PLAN COVERAGE (Must submit Opt Out Affidavit)**
- ☐ **NO CHANGE TO MEDICAL**

DENTAL PLAN OPTIONS - CHOOSE ONE

- ☐ **KAISER 15 DENTAL PLAN**
- ☐ **DELTA DENTAL 50 PLAN**
- ☐ **WILLAMETTE DENTAL GROUP PLAN**
- ☐ **NO DENTAL PLAN**
- ☐ **NO CHANGE TO DENTAL**

EMPLOYEE AGREEMENT

By signing below, I hereby certify the information furnished on this form is complete and accurate. I authorize Multnomah County to reduce my wages for the required premiums, if applicable, in accordance with my Union contract or County Personnel Rules for the coverage I have elected.
I understand:

- ✓ I will report changes to my enrolled dependent's status immediately to the Employee Benefits Office.
- ✓ a non-Spouse partner and non-Spouse partner's children do not meet the IRS criteria for tax-favored health benefits, and I will be subject to additional taxes on the value of their coverage.
- ✓ if I am in unpaid status and health plan coverage remains in force, I agree unpaid premium cost shares will be recovered from my paycheck when I return to paid status in accordance with withholding guidelines and my union contract or exempt ordinance.
- ✓ if my employment status changes I understand that my costshares could increase or decrease, or I may lose eligibility for a plan I have selected.
- ✓ 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.
- ✓ I agree and accept that the Multomah County Employee Benefits Office may communicate with me via email at my work email address with my specific health plan enrollment information in the content.

Signed under penalty of perjury, under the laws of the State of Oregon (FORM MUST BE SIGNED)

Employee Signature _____ Date _____