MULTNOMAH COUNTY - NEW HIRE BENEFIT ENROLLMENT FORM

MCCDA, FOPPO, IUOE, Prosecuting Attorneys, DSA and Civil Deputies

PLAN YEAR JANUARY 1 THROUGH 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

ENROLLMENT INFORMATION - LIST 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

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

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

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

Note: When enrolling a spouse/domestic partner, you must also complete and submit an Affidavit of Marriage or Domestic Partnership form (available on-line or from the Employee Benefits Office) .

MEDICAL PLAN OPTIONS CHOOSE ONE

- ☐ **KAISER PERMANENTE MEDICAL PLAN**
- ☐ **KAISER PERMANENTE MAINTENANCE PLAN - Part-Time Employees Only**
- ☐ **PERFORMANCE PPO MEDICAL PLAN**
- ☐ **PREFERRED PPO MEDICAL PLAN**
- ☐ **MAJOR MEDICAL PLAN**
- ☐ **OPT OUT OF MEDICAL PLAN COVERAGE (Must attach Opt-Out Affidavit)**

DENTAL PLAN OPTIONS CHOOSE ONE

- ☐ **KAISER PERMANENTE DENTAL PLAN:**
- ☐ **DELTA DENTAL PLAN:**
- ☐ **WILLAMETTE DENTAL GROUP PLAN:**
- ☐ **NO DENTAL PLAN**

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 _____