Retiree Benefits
Open Enrollment Form

Form Instructions: Bottom of page 2

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

Effective Date: January 1, 2025

1. Retiree Information (please print)	☐ **Change of Address**
Name (Last name, First Name)	
Address, Street, City, State and Zip	
Home/Cell Phone	Email Address

2. Choose One Medical Plan

- ◯ **Kaiser 10/20 Medical**
- ◯ **Kaiser Maintenance Medical** (Only available to non-Medicare eligible retirees)
- ◯ **Moda PPO 400 Medical**
- ◯ **Moda Major Medical**
- ◯ **No Medical Plan** (If you elect not to enroll or cancel, you may not be able to enroll in the future)

3. Choose One Dental Plan

- ◯ **Kaiser 15 Dental**
- ◯ **Delta 50 Dental**
- ◯ **Willamette Dental**
- ◯ **No Dental Plan** (If you elect not to enroll or cancel, you may not be able to enroll in the future)

4. 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 ☐

5. Comments

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 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.

6. Signature

X_____ _____

Retiree Signature **Date**

Typing your name and then attaching this form to an email is allowable for esignature.

Return to Multnomah County Benefits Office by **November 20, 2024**

Email: Retiree.benefits@multco.us
US Mail: Multnomah County Benefits
501 SE Hawthorne, Suite 400, Portland OR 97214
FAX: 503-988-6257

Questions: 503-988-5651

Form Instructions:

- Select type of change. You can select more than one option.
- Section 1: Enter retiree's name, address, phone number and email address.
- Section 2: Choose medical plan you are continuing or selecting for 2025, or choose "No Medical plan" if you are not currently enrolled in medical or you wish to cancel your medical coverage.
- Section 3: Choose dental plan you are continuing or selecting for 2025, or choose "No Dental plan" if you are not currently enrolled in dental or you wish to cancel your dental coverage.
- Section 4: List any eligible dependents who will continue coverage or be added onto coverage for 2025, and indicate if they are continuing/enrolling in medical and/or dental.
- Section 5: Clarify what changes you are making if needed.