Retiree Benefits Enrollment/Change Form

Form Instructions: Bottom of page 2

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 10/20 Medical**
- ◯ **Kaiser Maintenance Medical**
- ◯ **Moda PPO 400 Medical**
- ◯ **Moda Major Medical**
- ◯ **No Medical Plan** (You cannot re-enroll)

3. Select one:

- ◯ **Kaiser 15 Dental**
- ◯ **Delta 50 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 (Electronic signature allowed) **Date**

Returning from Enrollment Deferral Only:

By signing below, I acknowledge that I am exercising my **one-time** opportunity to return to County retiree medical and/or dental coverage due to loss of other qualifying health insurance coverage. I have remained continuously covered in a qualifying health insurance plan since ending Multnomah County coverage.

X _____ _____

Retiree Signature (Electronic signature allowed) **Date**

Email: Retiree.benefits@multco.us
US Mail: Multnomah County Benefits
501 SE Hawthorne, Suite 320, Portland OR 97214
FAX: 503-988-6257
Voicemail: 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, or choose "No Medical plan" if you are a retiree who is not currently enrolled in medical or you wish to cancel your medical coverage.
- Section 3: Choose dental plan you are continuing or selecting, or choose "No Dental plan" if you are a retiree who is 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, and indicate if they are continuing/enrolling in medical and/or dental.
- Section 5: Clarify why you are making a change, and what changes you are making.