Oregon Episcopal School
Universal Enrollment / Change Form

Employee Name			☐ Married ☐ Single	Enrollment Reasons: ☐ New Hire ☐ Open Enrollment ☐ Plan Change ☐ Add Dependent ☐ Add Newborn ☐ Add Domestic Partner: Date of Domestic Partnership ________ ☐ Delete Self or Dependent ☐ Marriage: Date ___________ ☐ Court Order ☐ Adoption (legal documents required) ☐ Loss of Other Coverage ☐ Employee Entered Eligible Class ☐ COBRA	
Job Title	Date of Birth	SS#			
Date of Hire	Date of Eligibility		Effective Date		
Home Address				Home Phone	Email Address

Enrollment Information: DP* = Domestic Partner

Medical Plan Choice: Providence: ☐ **Open Option PPO $0 Deductible** ☐ **Value Personal Option $1,000 ($500) Deductible** ☐ **HSA**

Add	Drop	Waive	If Waiving, select reason	Relationship to Employee	Gender M / F	Last Name	First Name	M I	Date of Birth	SS#	Full Time Student Y / N
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Self		Same as above	Same as above				
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Spouse ☐ DP*							
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Dependent							
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Dependent							

Dental: ☐ **Delta Dental (MODA) Group #10005020** ☐ **Kaiser** ☐ **Willamette Dental**

Add	Drop	Waive	If Waiving, select reason	Relationship to Employee	Gender M / F	Last Name	First Name	M I	Date of Birth	SS#	Full Time Student Y / N
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Self		Same as above	Same as above				
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Spouse ☐ DP*							
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Dependent							
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Dependent							

Vision: VSP ☐ **Matches Medical Enrollment** ☐ **Matches Dental Enrollment**

Add	Drop	Waive	If Waiving, select reason	Relationship to Employee	Gender M / F	Last Name	First Name	M I	Date of Birth	SS#	Full Time Student Y / N
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Self		Same as above	Same as above				
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Spouse ☐ Dependent							
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Spouse ☐ Dependent							
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other	☐ Spouse ☐ Dependent							

Open Enrollment Changes: If you are changing plans or deleting a dependent, please indicate your current plan you wish to terminate:

Medical: ☐ Providence Open Option $0 Deductible PPO ☐ Providence Value Personal Option $500 Deductible PPO ☐ Providence HSA

Dependents: ____

Dental: ☐ Delta Dental (MODA) ☐ Kaiser ☐ Willamette Dental

Dependents: ____

Do any of your dependents have a different mailing address? ☐ No ☐ Yes, complete the following: Dependent's Name: ___________________________

Dependent's mailing address: ____

Is any child over the dependent age limit applying for coverage due to disability? ☐ No ☐ Yes, complete and attach supporting documentation

Did you and/or any of your dependents have health insurance prior to enrolling on the OES benefit program? ☐ No ☐ Yes, attach your Certificate of Creditable Coverage from your current or prior health plan. You may be eligible for prior coverage credit towards pre-existing or other coverage limitations.

Do you and/or any of your dependents have health coverage (including Medicare) that will remain in effect after your medical coverage begins?

☐ No ☐ Yes, complete and attach your Coordination of Benefits form. Other insured's DOB / /

If Medicare indicate ☐ Part A ☐ Part B Effective Date / /

Sun Life
Beneficiary Information **X Life/AD&D X LTD**

Last Name	First Name	MI	Relation to You	Benefit %
If beneficiary is not living , then pay:				

LTD Plan:	OES policy indicates that all faculty with at least half-time contracts and staff working more than 1,000 hours per fiscal year are required to enroll in the LTD plan and premium will be deducted from your paycheck. The advantage to you is that disability benefits will be paid tax free in the event of a claim.

Employee Signature: **Date:**

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. If I decline coverage for myself and/or dependents I acknowledge that those declined will have to wait to be enrolled until the next Open Enrollment period or qualifying event. **I authorize my employer to make the necessary deductions from my wages to pay the premium when insurance becomes effective.**

HR USE Date Enrolled: Medical Dental VSP Life/AD&D FSA HSA Supp. Life