City of Portland Section I	**Annual Enrollment CHANGE Form – Due May 24, 2019** **Complete ONLY if you are making changes** **Plan Year July 1, 2019 – June 30, 2020**	**RETIREE & COBRA**

Last name	First Name	Date of Birth	
ADDRESS	CITY	STATE	ZIP CODE
HOME or CELL PHONE NUMBER ( )	EMAIL ADDRESS		

Section II DEPENDENT INFORMATION

Please review the enclosed benefit statement to verify that your current dependent information is up-to-date

Dependent Eligibility Requirements:

1. Your lawful **spouse or domestic partner** may be covered.
2. An eligible child up to age 26 is defined as follows:
   - **biological child**,
   - **stepchild, grandchild** of an employee's/retiree's child who is under the age of 26 & lives with the employee/retiree
   - **child** required to be covered by participant or participant's spouse as a result of divorce decree or court order to provide coverage.
   - **adopted child** or child placed for adoption, or
   - **eligible child of an enrolled domestic partner** (as declared on the Domestic Partner Affidavit).
     - A child cannot be in active military status and be eligible under the Plan.
     - An adult child's spouse is not eligible for coverage.

YOU MUST COMPLETE THIS SECTION IF YOU ARE ADDING OR REMOVING A DEPENDENT

	Reason for Change	Last name, First name	Sex	Date of Birth	Relationship
❑ **Adding** ❑ **Removing**					❑ Spouse ❑ Partner ❑ Child
❑ **Adding** ❑ **Removing**					❑ Spouse ❑ Partner ❑ Child

ADDING A DEPENDENT TO COVERAGE:

If you are adding a dependent, you ***MUST*** provide required documentation:

- Marriage license or notarized Domestic Partner Affidavit for both you and your domestic partner
- Birth certificates, adoption papers, legal custody awarded by a court, and/or divorce decree

FAMILY STATUS CHANGES DURING THE PLAN YEAR:

In general, your Annual Enrollment elections will stay in effect from July 1, 2019 through June 30, 2020. However, you may be approved to make election changes if you have a qualifying family status change and you notify the Benefit Office of the change within 60 days of the qualifying event. You must also submit any required supporting documentation. Any change to your elections must be on account of and consistent with the qualifying family status change. Examples include:

- Medicare eligible, Age 65.
- Marriage, domestic partnership, divorce, legal separation, or termination of domestic partnership
- Addition of a child through birth, adoption, legal guardianship, marriage, or domestic partnership
- Dependent child gaining or losing eligibility for benefit coverage
- Changes to your spouse's/domestic partner's employment that causes the loss of eligibility for continued participation in your spouse's/domestic partner's employer's benefits program
- Death of a spouse/domestic partner or child

DO NOT RETURN THIS FORM TO THE BENEFITS OFFICE IF YOU ARE NOT MAKING CHANGES

Section III — Medical/Vision Elections

Please (X) check your election for the following plans and list participants on lines below:

❑ **NO Medical and Vision Coverage**

	Monthly Premiums
❑ **CityCore Medical & VSP Vision** _____ _____	❑ $698.05 One Party ❑ $1,318.37 Two Party ❑ $1,872.91 Family
❑ **CityCore Medical & VSP Vision *Buy-Up*** _____ _____	❑ $704.60 One Party ❑ $1,330.28 Two Party ❑ $1,888.78 Family
❑ **High Deductible (Moda) & VSP Vision** _____ _____	❑ $594.14 One Party ❑ $1,028.01 Two Party ❑ $1,455.98 Family
❑ **High Deductible (Moda) & VSP Vision *Buy-Up*** _____ _____	❑ $555.69 One Party ❑ $1,039.92 Two Party ❑ $1,471.85 Family
❑ **Kaiser NW Medical & Vision** _____ _____	❑ $712.88 One Party ❑ $1,347.80 Two Party ❑ $1,915.87 Family
❑ **Kaiser Senior Advantage (Medicare participants only)** _____ _____	❑ $339.70 One Party ❑ $634.84 Two Party
❑ **EAP (Employee Assistance Program**	❑ $4.20 ❑ $5.25 for PFFA only

What is EAP? A confidential counseling program, and more… www.cascadecenters.com; (800) 433-2320

Section IV — Dental Plan Elections (ONLY CURRENT PARTICIPANTS CAN MAKE CHANGES)

Please (X) check your election for the following plans and list participants on lines below:

❑ **No Dental Coverage (If you cancel, you CANNOT re-elect later)**

	Monthly Premiums
❑ **Delta Dental** _____ _____	❑ $58.84 One Party ❑ $101.62 Two Party ❑ $180.56 Family
❑ **Delta Dental *Buy-Up*** _____ _____	❑ $75.44 One Party ❑ $132.02 Two Party ❑ $215.00 Family
❑ **Kaiser NW Dental Plan** _____ _____	❑ $73.46 One Party ❑ $146.92 Two Party ❑ $220.38 Family

Section V IRREVOCABLE ANNUAL ELECTIONS

You cannot change or revoke your elections until the next Annual Enrollment period, unless you have **a qualifying family status change**. Examples of such events include:

1. A change in your marital status
2. A change in the number of your tax dependents who are eligible to be enrolled under City coverage
3. A change in your, your spouse/domestic partner's, or dependent's employment status
4. A change such that your dependent satisfies or ceases to satisfy dependent eligibility requirements
5. A change in your, your spouse/domestic partner's, or dependent's residence

Should a change occur that you think would qualify for a change in election, you must complete a Notice of Change in Family Status form and attach required documents (such as birth certificate, marriage license, student status verification, divorce decree, etc.) and send them to the Benefit Office within 60 days of the event.

If you fail to notify and/or provide the required information within 60 days of the event, you must wait until next annual enrollment. A change to delete a dependent will be effective retroactive to the date of the event. (such as divorce, or dependent no longer eligible under the City of Portland Plan rules) You will be financially responsible for any claims that were processed after eligibility should have ended.

Certification of Understanding

I have read and understand all of the information and conditions to continue retiree healthcare coverage contained in this enrollment form. All information provided by me in this enrollment form is truthful and accurate.

I further understand that the City Benefit Office may require additional documentation to verify eligibility to continued retiree benefit coverage for myself and any domestic partner, spouse or dependent and that such coverage is contingent on my providing documentation that the City Benefit Office may require.

I further understand that I must report any change of family status within 60 days of the change. I am financially responsible for payments made by any City benefit plan that are ineligible for payment as a result of a family status change and will be required to reimburse the City of Portland for such payments.

I further understand that I must enroll myself, domestic partner, spouse or dependent in Medicare and/or Medicaid when eligible to do so, whether I become eligible for Medicare and/or Medicaid due to disability or age and inform the City Benefit Office within 60 days of enrollment, and that I must provide the City Benefit Office with enrollment information about other health plans or insurers that provided coverage for me, my domestic partner, spouse or dependent while I am covered under any City sponsored healthcare plan during my retirement.

I further understand that if I or my domestic partner, spouse, or dependent fraudulently obtain any City benefits, the City of Portland will seek criminal prosecution to the full extent of the law.

_____

Signature of Participant

QUESTIONS?

Call 503-823-6136 or e-mail retireebenefits@portlandoregon.gov; Fax: 503-823-3522

Please submit this enrollment change form if you are making changes

Deadline for submittal of form: May 24, 2019

Mailing address:

City of Portland
Benefits Office/Retiree
1120 SW 5th Ave Rm 404
Portland, OR 97204

Office Location:

Bureau of Human Resources
Columbia Square Building
111 SW Columbia St, Suite 550
Portland, OR 97201

Health & Financial Benefits
HEALTHY LIVING. HEALTHY FUTURE.