

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

CityNet Medical & VSP Vision

Monthly Premiums

- \$644.22 One Party
- \$1,253.46 Two Party
- \$1,679.42 Family

CityNet Medical & VSP Vision Buy-Up

- \$650.94 One Party
- \$1,265.66 Two Party
- \$1,695.70 Family

High Deductible (Moda) & VSP Vision

- \$480.20 One Party
- \$922.60 Two Party
- \$1,231.93 Family

High Deductible (Moda) & VSP Vision Buy-Up

- \$486.92 One Party
- \$934.80 Two Party
- \$1,248.21 Family

Kaiser NW Medical & Vision

- \$607.44 One Party
- \$1,170.30 Two Party
- \$1,733.18 Family

Kaiser Senior Advantage (Medicare participants only)

- \$339.70 One Party
- \$634.84 Two Party

EAP (Employee Assistance Program)

- \$5.25

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)

Delta Dental

Monthly Premiums

- \$57.42 One Party
- \$99.20 Two Party
- \$176.23 Family

Delta Dental Buy-Up

- \$66.30 One Party
- \$114.57 Two Party
- \$203.55 Family

Kaiser NW Dental Plan

- \$69.24 One Party
- \$138.46 Two Party
- \$207.70 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, 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 Subscriber

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.

