



Retiree Benefits Enrollment/Change Form

For Retirees from:

Local 88, Non-Represented, MCCDA, DSA/CD, ONA, Prosecuting Attorneys, Dentists, ONA, Painters, Physicians, JCSS

Select:	Retiree Enrollment	Add Dependent	Remove Dependent	End Enrollment	Change Plans	Dependent Only
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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
Name	SSN	Relationship	DOB	Gender	Medical Dental
Name	SSN	Relationship	DOB	Gender	Medical Dental
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

Email: Retiree.benefits@multco.us
US Mail: Multnomah County Benefits
501 SE Hawthorne, Suite 400, Portland OR 97214
FAX: 503-988-6257
Voicemail: 503-988-5651