HEALTH PLANS ENROLLMENT/CHANGE FORM

Please use black or blue ink if completing a paper form.
Email completed forms to: MCEmployeeBenefits@co.marion.or.us

Effective Date ☐

A. PLAN OPTIONS

You must make a selection for medical AND dental. Please note: Unit 5/MCLEA employees are not eligible for the PacificSource High Deductible Health Plan (HDHP).

MEDICAL INSURANCE OPTIONS:	DENTAL INSURANCE OPTIONS:
☐ Kaiser HMO	☐ Kaiser Dental HMO
☐ PacificSource Traditional PPO	☐ Delta Dental PPO
☐ PacificSource HDHP-**Unit 5/MCLEA INELIGIBLE**	

B. EMPLOYEE INFORMATION

Last Name | First Name | MI | Birth Date (MM/DD/YY) | Gender

Home Address | Social Security # | Marital Status

City | State | Zip | Phone Number

Department | Date of Hire | Unit | Employee #

C. REASON FOR COMPLETING FORM (Check all that apply)

☐ **New Hire** ☐ **Open Enrollment**

☐ **Name Change** ☐ **Address Change**

☐ **Eligibility or Status Change**

Adding Dependent(s)

Please complete dependent information on Page 2

Form must be turned in within 30 days of event

Date of Event: _____

☐ **Birth** ☐ **Marriage *** ☐ **Adoption ***

☐ **Domestic Partner *** **Other Reason:** _____

*** Include Marriage Certificate, Declaration of Oregon Registered Domestic Partnership, Affidavit of Domestic Partnership, or Adoption Documentation.**

Deleting Dependent(s)

Form must be turned in within 30 days of event

Date of Event: _____

☐ **Term Domestic Partner **** ☐ **Divorce *** ☐ **Death**

Other Reason: _____

*** Include the page on your divorce decree showing date divorce was granted.**

**** Include the Statement of Domestic Partner Cvg. Termination.**

Name to Delete: _____

Address: _____

Name to Delete: _____

Address: _____

I apply for membership for the persons listed above and agree that we shall abide by the provisions of the applicable health plan selected. I certify that the information on this application is true and correct. I hereby authorize any medical care institution or medical provider to give my insurance carriers any information related to the physical or mental condition, medical history, or medical treatment of me or my family members requested in the underwriting of my application or in administering claims under my plan(s). This authorization will remain valid so long as I remain eligible for benefits. Furthermore, I hereby authorize Marion County to make any applicable deductions from my pay for insurance premiums. I understand this election is binding until revoked or modified by me during an open enrollment or upon an event that qualifies for a plan change. I will be automatically enrolled in the pre-tax Employee Insurance Premium Contribution Flexible Spending Account for any premium contributions. I have read and agree to the Employee Insurance Premium Contribution Account Agreement information on page 2 of this form. Unless I specifically contact Employee Benefits and sign that I want my premium deductions taken on a post-tax basis, I understand that my premium deductions will be taken pre-tax.

Employee Signature _____ Date _____

☐ No Dependents

☐ Dependents on other side

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Employee Name: ______________________ Employee #: __________

D. DEPENDENT INFORMATION Please list ALL those who are eligible to be covered on your plan.

☐ Spouse ☐ Domestic Partner

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

Dependent Legal Relation: __________

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

Dependent Legal Relation: __________

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

Dependent Legal Relation: __________

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

Dependent Legal Relation: __________

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

If any persons are covered by other insurance, including Medicare or another County Employee, please indicate who and provide name of other insurance and policy number to assist with Coordination of Benefits :

If enrolling in the pre-tax Employee Insurance Premium Contribution FSA, please read the agreement below.

Employee Insurance Premium Contribution Account Agreement

In consideration of my participation in the Flexible Spending Account (FSA) Employee Insurance Premium Contribution, I acknowledge and agree to the following:

1. ACCEPTABLE FSA PLAN TERMS: I agree to abide by the terms, conditions and provisions of the FSA contained in the plan document. I acknowledge my right to examine the plan document or obtain a copy of it by giving reasonable advance notice.

2. PLAN MODIFICATION: I have been informed that the FSA offered by my employer may be modified from time to time and I agree that my employer may cancel or amend the FSA according to their independent judgement and discretion without my consent or prior notice to me.

3. SOCIAL SECURITY: I choose to participate in the FSA despite my knowledge that my salary reduction elections may reduce my FICA withholding (Social Security) and that this may reduce my Social Security benefits upon retirement.

4. SEEK LEGAL ADVICE: I have been informed that my participation in the FSA will have tax and economic consequences to me and that before deciding to participate in the FSA, I should seek the advice of an attorney or tax consultant regarding the benefits, risks and limitations of the FSA.

5. IRREVOCABLE ELECTION: I understand I cannot change or revoke my election until the open enrollment period for the new plan year. I will be able to change my election if I have a change in status as outlined in the Plan Document. The election change must be requested within 30 days of the event and must be on account of and consistent with the change in status.