Oregon TECH
Human Resources

Employee Leave Checklist
Parental Leave

Parental leave provides 12 weeks of leave to bond with a newborn, adopt a child, or for placement of a foster child.

STEP 1: INFORMATION TO READ AND REVIEW

- □ FMLA Employee Rights Notice
- □ OFLA Employee Rights Notice
- □ OIT Notice of Employee Rights

STEP 2: COMPLETE LEAVE REQUEST FORM

- □ FMLA/OFLA Leave Request Form – complete and return to HR

STEP 3: CERTIFICATION

- □ Certification – provide a copy of the birth record, adoption, or foster child placement paperwork.

STEP 4: LEAVE AND LEAVE BENEFITS

- □ Complete your FMLA/OFLA Attendance Record/Leave Tracking Form and your Employee Leave slip every month

STEP 5: BENEFITS CHANGES (if you want to add new child to your benefits)

- □ Mid-Year Change Form - submit to HR within 30 days. Attach a copy of the birth record.
- □ Open Enrollment Correction Form - For babies born after Open Enrollment ONLY

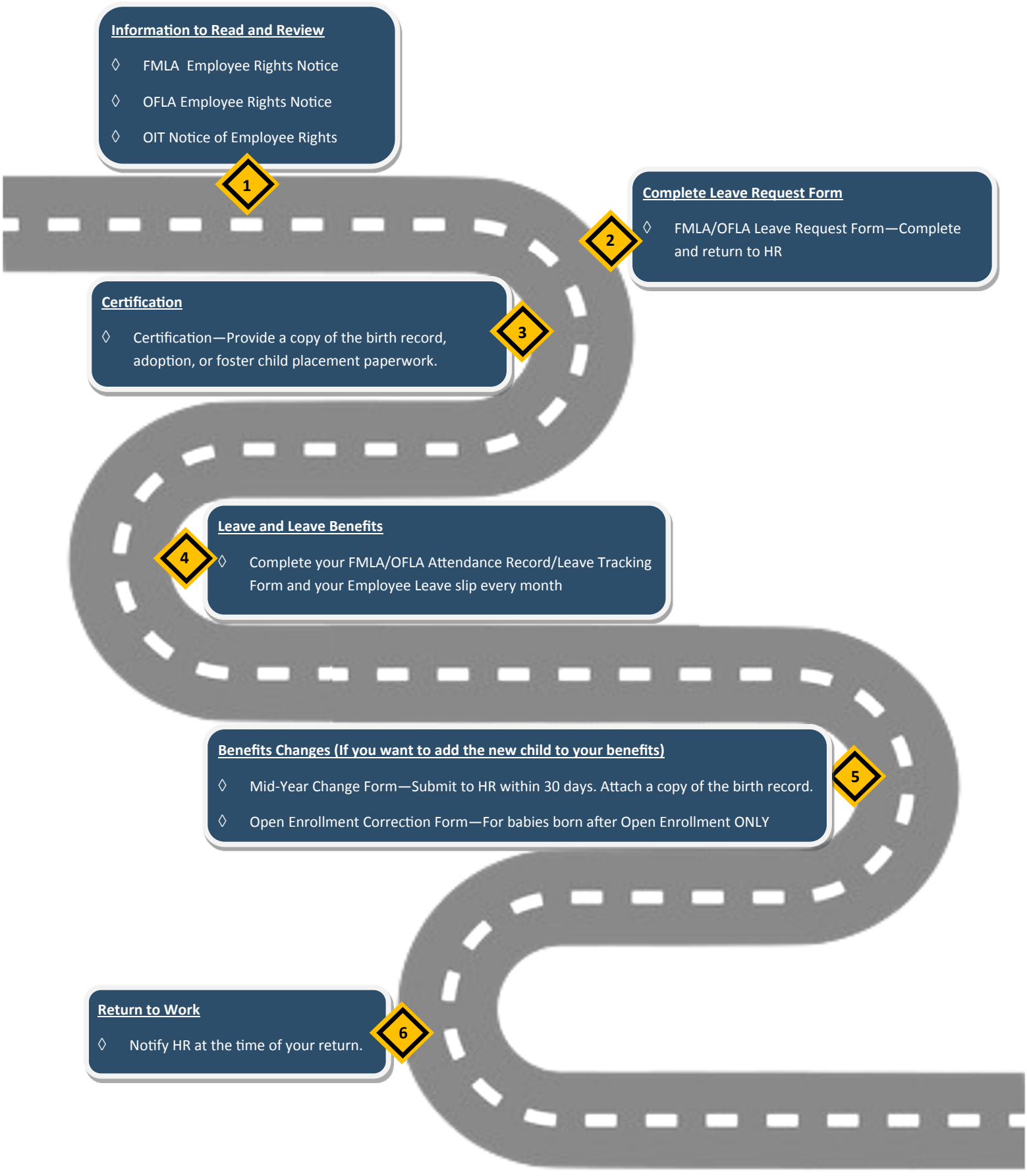
STEP 6: RETURN TO WORK

- □ Notify HR at the time of your return

Oregon TECH
Human Resources

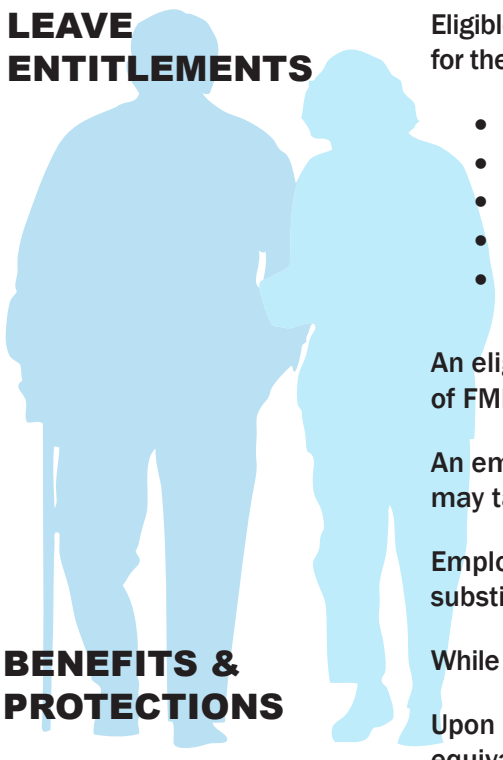
Employee Road Map to Medical Leave

Parental Leave



EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

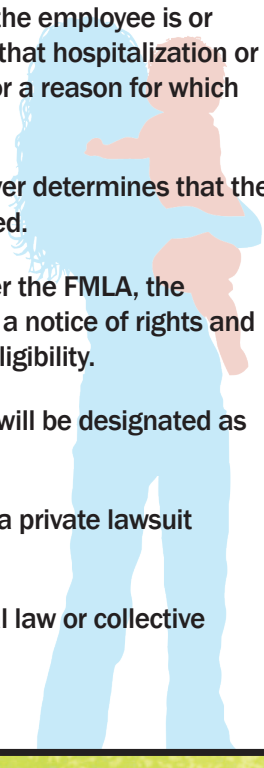
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

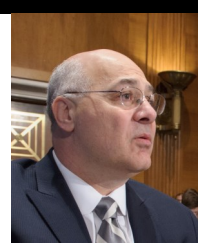
U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

BUREAU OF LABOR AND INDUSTRIES

Oregon FAMILY LEAVE ACT

Brad Avakian, Commissioner



NOTICE TO EMPLOYERS AND EMPLOYEES

The Oregon Family Leave Act (OFLA) requires employers of 25 or more employees to provide eligible workers with protected leave to care for themselves or family members in cases of death, illness, injury, childbirth, adoption and foster placement. ORS 659A.150-659A.186

When can an Employee take Family Leave?

Employees can take family leave for the following reasons:

- **Parental Leave** during the year following the birth of a child or adoption or foster placement of a child under 18, or a child 18 or older if incapable of self-care because of a mental or physical disability. Parental leave includes leave to effectuate the legal process required for foster placement or adoption.
- **Serious health condition leave** for the employee's own serious health condition, or to care for a spouse, same-gender domestic partner, custodial parent, non-custodial parent, adoptive parent, foster parent, biological parent, step parent, parent in law, parent of same-gender domestic partner, grandparent, grandchild, a person whom the employee is or was a relationship of in loco parentis, biological, adopted, foster or step child of an employee or the child of an employee's same-gender domestic partner.
- **Pregnancy disability leave** (a form of serious health condition leave) taken by a female employee for an incapacity related to pregnancy or childbirth, occurring before or after the birth of the child, or for prenatal care.
- **Sick child leave** taken to care for an employee's child with an illness or injury that requires home care but is not a serious health condition.
- **Bereavement leave** to deal with the death of a family member.
- **Oregon Military Family Leave** is taken by the spouse or same gender domestic partner of a service member who has been called to active duty or notified of an impending call to active duty or is on leave from active duty during a period of military conflict.

Who is Eligible?

To be eligible for leave, workers must be employed for the 180 day calendar period immediately preceding the leave and have worked at least an average of 25 hours per week during the 180-day period.

Exception 1: For parental leave, workers are eligible after being employed for 180 calendar days, without regard to the number of hours worked.

Exception 2: For Oregon Military Family Leave, workers are eligible if they have worked at least an average of 20 hours per week, without regard to the duration of employment.

Exception 3: For compensable Workers Compensation injuries, for certain Workers Compensation injuries involving denied and then accepted claims and for certain accepted claims involving more than one employer.

Exception 4: When an employee is caring for a family member with a serious health condition and the same family member dies, the employee need not requalify with the 25 hour per week average to be eligible for bereavement leave.

How much Leave can an Employee take?

- Employees are generally entitled to a maximum of 12 weeks of family leave within the employer's 12-month leave year.
- A woman using pregnancy disability leave is entitled to 12 additional weeks of leave in the same leave year for any qualifying OFLA purpose.
- A man or woman using a full 12 weeks of parental leave is entitled to take up to 12 additional weeks for the purpose of sick child leave.
- Employees are entitled to 2 weeks of bereavement leave to be taken within 60 days of the notice of the death of a covered family member.
- A spouse or same gender domestic partner of a service member is entitled to a total of 14 days of leave per deployment after the military spouse has been notified of an impending call or order to active duty and before deployment and when the military spouse is on leave from deployment.

What Notice is Required?

Employees may be required to give 30 days notice in advance of leave, unless the leave is taken for an emergency. Employers may require that notice is given in writing. In an emergency, employees must give verbal notice within 24 hours of starting a leave.

Is Family Leave paid or unpaid? Benefits?

- Although Family Leave is unpaid, employees are entitled to use any accrued paid vacation, sick or other paid leave.
- Employees are entitled to group health insurance benefits during family leave as if they continued working.

How is an Employee's job Protected?

Employers must return employees to their former jobs or to equivalent jobs if the former position no longer exists. However, employees on OFLA leave are still subject to nondiscriminatory employment actions such as layoff or discipline that would have been taken without regard to the employee's leave.

FOR ADDITIONAL INFORMATION:

Employer Assistance . . .971-673-0824
Portland 971-673-0761
Eugene 541-686-7623
Salem 503-378-3292

www.oregon.gov/BOLI

BOLI
Civil Rights Division
800 NE Oregon, #1045
Portland, OR 97232

Employees who have been denied available leave, disciplined or retaliated against for requesting or taking leave, or have been denied reinstatement to the same or equivalent position when they returned from leave, may file a complaint with BOLI's Civil Rights Division.

This is a summary of laws relating to Oregon Family Leave Act. It is not a complete text of the law.

January 2016

THIS INFORMATION MUST BE POSTED IN A CONSPICUOUS LOCATION

Oregon TECH
Human Resources

Notice of Employee Rights and Responsibilities
FMLA/OFLA Leave

If your leave qualifies for FMLA and/or OFLA leave, you will have the following rights and responsibilities:

Leave Entitlement: Effective the first day of your leave, time taken under the protected leave laws is counted against your leave entitlement. Generally you are entitled to 12 weeks of protected leave in a rolling 12-month period. The rolling 12-month period is measured backward from the date of any protected leave usage. Some leave types may be entitled to additional protected leave.

Paid Leave: You will be required to use your paid accruals (sick, vacation, etc.) during your FMLA/OFLA leave. This means you will use your paid leave (sick, vacation, etc.) and that such leave will also be considered protected under the FMLA/OFLA leave and counted against your protected leave entitlement.

- All Employees must use available accrued sick leave during FMLA/OFLA leave, unless the employee is on approved FMLA and is utilizing his/her short-term disability benefit.

- Classified Employees: Classified employees must use all accrued vacation leave during FMLA/OFLA leave before going in to unpaid status (leave without pay), unless the employee is on approved FMLA and is utilizing his/her short-term disability benefit. See the Oregon Public Universities/SEIU Collective Bargaining Agreement, Article 47-Vacation Leave, Section 14, regarding an employee's option to retain up to 40 hours of accrued vacation leave.

  Upon exhausting all accrued sick leave, classified employees may use accrued compensatory time, and/or personal leave during FMLA/OFLA leave.

  After exhausting all paid leave, classified employees may request hardship leave donations. See the Oregon Public Universities/SEIU Collective Bargaining Agreement, Article 40 – Sick Leave, Section 8.

- Unclassified Employees (faculty and administrative staff): Upon exhausting all accrued sick leave, unclassified employees may use accrued vacation leave time during FMLA/OFLA leave before going in to unpaid status (leave without pay).

- Employees may not go in and out of unpaid status, unless on approved FMLA/OFLA and receiving short-term disability benefits through Standard Insurance.

Benefits: Approved FMLA and OFLA Leave: Your health insurance coverage will continue provided you continue to contribute your portion of the premiums. Premiums will be deducted through normal payroll deduction when available. An employee who is in leave without pay status during FMLA and/or OFLA leave will be responsible to self-pay their portion of health insurance premiums directly to the University. Employee paid optional benefit premiums may be also be continued when self-paid by the employee.

If you do not return to work following FMLA and/or OFLA leave you may be required to reimburse the University for the employer share of health insurance premiums paid on your behalf during your leave.

Medical Certification: In order to determine whether an employee's absence qualifies for protected leave under the FMLA and OFLA leave laws, you may be required to provide a medical certification from a qualified health care provider within 15 calendar days of the receipt of your notice for eligibility to take protected leave. It is the

employees' responsibility to ensure a complete and sufficient medical certification is returned to Human Resources within the designated timeframe.

While on approved FMLA or OFLA leave, you may be required to furnish additional medical certifications if requested by Human Resources. The interval between re-certifying will not be less than 30 days, unless the circumstances for your leave have changed significantly.

Failure to provide a complete and sufficient Medical Certification may result in your leave being denied. Denied FMLA and/or OFLA is not protected under the leave statutes and the University may treat the absences as unexcused.

Periodic Check In: While on leave, you are required to check in periodically with Human Resources. You should provide information on your status, any change in circumstances, and if out for a continuous block of time, your intent to return work.

Status Changes: You are required to notify Human Resources if the status of your leave requirements changes. Status changes may include, but are not limited to: a need for continuous leave while on approved intermittent leave; a need for more intermittent leave than the amount currently approved; or a need for leave beyond the current approved end date. If you are on approved leave and no longer require time off for the approved reason, please contact Human Resources to close your file.

Leave Reporting: You are required to record any FMLA/OFLA leave taken on a leave tracking form which should be provided to Human Resources monthly.

Return to Work: If the status of your situation changes and you do not anticipate returning on your scheduled return date, you are expected to notify your supervisor and the Human Resources office as soon as possible.

When you return, you must be able to carry out the essential functions of your position. If your leave was for your own Serious Health Condition, you will be required to provide either a Return to Work form or a medical certification stating you are able to return to work without restrictions.

Reinstatement Rights: Upon returning from protected leave, you have the following reinstatement rights:

- FMLA: You must be reinstated to either the same position held when leave began or to an equivalent position. An equivalent position is one that is virtually the same as the employee's former position in terms of pay, benefits, and working conditions and must involve the same or substantially similar duties and responsibilities.
- OFLA: You must be reinstated to the position held when the leave began.

If you remain on leave after exhausting your protected leave entitlement (FMLA and/or OFLA), you will not have the reinstatement rights outlined above.

For additional information pertaining to leave, contact the Benefits Consultant at 541-885-1028.

Oregon TECH
Human Resources

Leave of Absence Request Form

EMPLOYEE INFORMATION					
Name:			**ID#:**		
Department:			**Job Title:**		
Employee Type:	❒ Classified	❒ Faculty	❒ Unclassified Admin		
Supervisor Name:					
Contact information while on leave					
Personal Email:					
Mailing Address:					
Phone:					

LEAVE INFORMATION	
I am requesting a leave of absence for the following reason:	
❒ My own serious health condition ❒ Birth of my child, and/or to care for the newborn child ❒ Placement of a child for adoption/foster care ❒ My child's NON-SERIOUS health condition	❒ To care for my family member with a serious health condition ❒ Qualifying military exigency leave ❒ Service member care leave (SMCL) ❒ Bereavement leave

If applicable, please specify the person the leave is for and the relationship:				
Name:				
Relationship:				
Is the condition due to an on-the-job injury or illness?	❒ Yes	❒ No	❒ N/A	

I am requesting a leave of absence with the following schedule:			
❒ Full-time leave from		to	
❒ Intermittent leave from		to	
❒ Reduced-schedule leave from		to	
Describe proposed intermittent or reduced schedule:			

COMPENSATION DURING LEAVE			
Will you be applying for Short Term Disability (STD)?	❒ Yes	❒ No	❒ N/A
Will you be using leave during any STD waiting period?	❒ Yes	❒ No	❒ N/A
Will you be using leave to supplement your STD payment?	❒ Yes	❒ No	❒ N/A

Specify the types of leave you wish to use, the dates on which to apply it, and the total for each.

❒ Sick Leave			❒ Vacation			❒ Compensatory Time			❒ Leave without Pay		
From	To	Hours	From	To	Hours	From	To	Hours	From	To	Hours
Total Sick		0.00	*Total Vacation*		0.00	*Total Comp*		0.00	*Total LWOP*		0.00

Use my special day on:		
Use my personal days on:		
I will use paid holidays on:		
I wish to retain		hours of vacation *(classified only, 40 hours maximum)*

_____ _____

Employee Signature **Date**

Oregon TECH
Human Resources

FMLA/OFLA ATTENDANCE RECORD / LEAVE TRACKING FORM

Name: _____
Department: _____
Employee ID#: _____
Instructions: Please record the number of hours you were off each day while on FMLA/OFLA leave. Include holidays.
Do not include days you would not have been expected to be at work (your normal days off).
Return this form at the end of each month.

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Jan																																	0.00
Feb																																	0.00
Mar																																	0.00
Apr																																	0.00
May																																	0.00
Jun																																	0.00
Jul																																	0.00
Aug																																	0.00
Sep																																	0.00
Oct																																	0.00
Nov																																	0.00
Dec																																	0.00

Employee's Signature: _____
Date: _____

Supervisor's Signature: _____
Date: _____

pebb
Public Employees' Benefit Board

Midyear Change Form

(Qualified Status Change (QSC))

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

See the Summary Plan Description and the QSC Matrix at www.pebbinfo.com.

Section 1: Employee information

PEBB benefit number (P########), OR#, University ID or Lottery ID

Gender ☐ M ☐ F ☐ Other

Last name | First name | M.I.

Date of birth *(mm/dd/yyyy)*

☐ Check if new address

Address | Apartment or space#

City | State | ZIP | County

Work phone number | Cell phone number (Optional) | Email (Optional)

Are you Medicare eligible? ☐ Yes ☐ No

Are you serving or did you ever serve in the military? ☐ Yes ☐ No

If "Yes," do you authorize PEBB to send your name and address to the Oregon Department of Veterans' Affairs (ODVA) for the purpose of receiving benefit information? ☐ Yes ☐ No

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary)*:

☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Section 2: What changed?

See the QSC Matrix at www.pebbinfo.com under Resources. The event date must be included below.
Dependent = Eligible Spouse, Domestic Partner or child.

☐ Marriage	Date
☐ Divorce or annulment	Date
☐ Addition of a domestic partnership (Include Domestic Partnership by Affidavit Form)	Date:
☐ Termination of domestic partnership	Date:
☐ Birth	Date:
☐ Adoption or placement for adoption (legal documentation required)	Date:
☐ Addition of a Child/Grandchild by Affidavit (Include appropriate PEBB Affidavit Form)	Date:
☐ Termination of a Child/Grandchild by Affidavit (Include appropriate PEBB Affidavit Form)	Date:
☐ Employee gains other group coverage	Date:
☐ Dependent gains other medical group coverage	Date:
☐ Dependent loses other medical group coverage	Date:
☐ Employment status change (describe)	Date:
☐ Death of a dependent or spouse	Date:
☐ National Medical Support Notice (NMSN)	Date:
☐ Move out of current plan's services area	Date:
Tobacco midyear change info (Self): ☐ Quit ☐ Never used ☐ Medical provider advised not to quit (medical condition) ☐ Used tobacco in previous 12 months ☐ Have not used tobacco products in the previous 12 months	Date:
Tobacco midyear change info (Spouse/Domestic Partner): ☐ Quit ☐ Never used ☐ Medical provider advised not to quit (medical condition) ☐ Used tobacco in previous 12 months ☐ Have not used tobacco products in the previous 12 months	Date:

Section 3: Dependent information

1. List all eligible family members you want to terminate or provide coverage for. Attach additional dependent sheet if necessary.
2. **Required Affidavits and appropriate legal documents for a Domestic Partner, Child or Grandchild by Affidavit need to be submitted along with the enrollment form no later than 5 business days from the submittal of this enrollment form.** Find necessary affidavits under Forms at www.pebbinfo.com.
   - *Note: Payroll offices will not process enrollment for the individual until all documentation has been submitted.*
3. Please see Oregon Administrative Rule (101-015-0011) concerning eligible dependents by affidavit at: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=6
4. **If you are terminating coverage for a dependent you MUST provide an address below for mailing of required COBRA notices.**

Dependent A ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic partner by Certificate ☐ Domestic partner by affidavit ☐ Child
☐ Step Child ☐ Partner's child ☐ Grandchild by affidavit (OAR 101-015-0011) ☐ Child by affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth *(mm/dd/yyyy)* | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address *(if different from employee address)* | City | State | ZIP

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent B ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic partner by Certificate ☐ Domestic partner by affidavit ☐ Child
☐ Step Child ☐ Partner's child ☐ Grandchild by affidavit (OAR 101-015-0011) ☐ Child by affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth *(mm/dd/yyyy)* | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address *(if different from employee address)* | City | State | ZIP

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent C ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Registered Domestic Partner ☐ Domestic Partner by Affidavit ☐ Child
☐ Step Child ☐ Partner's child ☐ Grandchild by Affidavit (OAR 101-015-0011) ☐ Child by Affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth *(mm/dd/yyyy)* | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address *(if different from employee address)* | City | State | ZIP

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent D ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Registered Domestic Partner ☐ Domestic Partner by Affidavit ☐ Child
☐ Step Child ☐ Partner's child ☐ Grandchild by Affidavit (OAR 101-015-0011) ☐ Child by Affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth *(mm/dd/yyyy)* | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address *(if different from employee address)* | City | State | ZIP

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent E ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Registered Domestic Partner ☐ Domestic Partner by Affidavit ☐ Child
☐ Step Child ☐ Partner's child ☐ Grandchild by Affidavit (OAR 101-015-0011) ☐ Child by Affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth *(mm/dd/yyyy)* | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address *(if different from employee address)* | City | State | ZIP

Ethnicity *(Select one)*: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race *(Select at least one. If selecting more than one, circle one as primary):*
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Section 4: Healthcare plan selections

A: Choosing *not to* enroll in a PEBB medical plan, select one of the following options:

☐ **OPT-OUT**

Opting Out of a medical enrollment is conditioned upon my understanding and attesting that the following statements are true:

- I and all other individuals for whom I reasonably expect to claim a personal tax exemption deduction have, or will have, an alternative medical coverage considered to be minimum essential coverage through an employer-sponsored medical plan for the taxable year 2020. You do not need to provide proof of alternative medical coverage. See information at http://www.oregon.gov/oha/pebb/benefits/opt-out.pdf
  1. The following coverages are not eligible to Opt-Out against Oregon Health Plan/Medicaid, Student Health, and individual market coverage.
- I understand my employer will not pay the monthly Opt-Out payment to me if my employer knows or has reason to know that I or any other member of my expected tax family does not have or will not have the alternative coverage.
- I understand that I must renew this attestation each plan year and applicable tax year for which I want the Opt-Out to apply.

By checking the Opt-Out box, and signing the form I verify the above statements are true.

☐ **Decline**

Select this option if you wish to decline all PEBB benefits. If you decline core benefits (medical/dental/vision/employee basic life), you're choosing to not participate in any of the PEBB programs. You will not received cash in lieu of the medical coverage and you are not eligible to enroll in any PEBB plans.

B: Medical

If enrolled in a Moda medical plan, each covered individual must choose a PCP 360 for that individual to receive the "in-network" benefit. If an individual has not chosen a PCP 360 with Moda, they will receive the "out-of-network" level benefits. A list of PCP 360 providers can be found at: https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml

Medical plan selection:	Full-time	Part-time
Kaiser Deductible (Kaiser vision included with full time plan)	☐	☐
Kaiser Traditional (HMO) (Kaiser vision included with full time plan)	☐	☐
Moda Synergy	☐	☐
Providence (PEBB) Statewide	☐	☐
Providence Choice	☐	☐

Full-time employees may only enroll in full-time plans. Part-time employees can enroll in either full-time or part-time plans. If a part-time employee enrolls in full-time plan the part-time employee will not receive the part-time subsidy.

C: Dental plan selection:	Full-time	Part-time
Kaiser Permanente Dental	☐	☐
Delta Dental Premier	☐	☐
Delta Dental PPO	☐	N/A
Willamette Dental Group	☐	N/A
☐ I decline dental enrollment		

Delta Dental late enrollment penalty

I understand **if I decline dental coverage** when initially eligible or allow coverage to lapse, then choose to enroll at a future Open Enrollment period with Delta Dental, any enrolled dependents and I will be subject to a 12-month waiting period for dental, and a 24 month wait for Orthodontic services. Only diagnostic and preventive care (*cleanings, x-rays, and exams*) will be covered during the waiting period.

Employee signature _____ Date _____

D: Vision plan selection:

- ☐ VSP Basic Plan
- ☐ VSP Plus — Includes the Basic Plan and PLUS additional benefits
- ☐ I decline VSP enrollment

Section 5: Tobacco usage

If you enroll in a Medical plan and do not complete this Section a tobacco surcharge ($25.00 per employee and $25.00 for spouse/partner enrolled in medical) will be deducted each month from your pay.

Check one box:

- ☐ I currently use tobacco, but my spouse/domestic partner currently does not use tobacco. ($25)
- ☐ I currently do not use tobacco, but my spouse/domestic partner currently uses tobacco. ($25)
- ☐ Both my spouse/domestic partner and I currently use tobacco. ($50)
- ☐ Both my spouse/domestic partner and I currently do not use tobacco. ($0)
- ☐ I currently use tobacco, and do not have a spouse/domestic partner covered in PEBB. ($25)
- ☐ I currently do not use tobacco, and do not have a spouse/domestic partner covered by PEBB. ($0)
- ☐ I do not enroll in PEBB medical plans.
- ☐ My or ☐ My spouse's or domestic partners' provider advised not to quit using tobacco (Medical Waiver). ($0)

Section 6: Other employer group coverage

When your spouse or Domestic Partner is enrolled in your PEBB medical coverage and has access to other group medical coverage (not a PEBB medical plan) from their employer's sponsored group plan, but does not enroll in it, $50 will be deducted from your monthly pay.

Check one box:

- ☐ My spouse/domestic partner has PEBB coverage as an eligible employee (Includes a spouse who enrolls in Opt-Out). ($0)
- ☐ My spouse/domestic partner has other employer group coverage, (not PEBB coverage) and enrolls for that coverage. ($0)
- ☐ My spouse/domestic partner has other employer group coverage available, (not PEBB coverage) but does not enroll in that coverage, and is enrolled in PEBB coverage. ($50)
- ☐ My spouse/domestic partner does not have other employer group coverage available. ($0)
- ☐ I do not cover a spouse or domestic partner in a PEBB medical plan. ($0)

Section 7: Optional plans

A: Optional life insurance

As a newly eligible employee for your first time enrollment, the Optional Employee Life has a guaranteed issue enrollment amount of up to $100,000 and Optional Spouse/Domestic Partner Life has a guaranteed issue enrollment amount of up to $20,000 without needing to submit a medical history to The Standard underwriting for approval.

You can find a link to the Medical History Statement on the PEBB website at:
http://www.oregon.gov/oha/PEBB/Pages/Forms.aspx

**Guaranteed issue means medical history is not required. If a initial request is made with a Qualified Status Change (QSC), guaranteed issue amount is applicable. You are required to submit a medical history statement on any coverage amount that is over guaranteed issue.

Employee optional life insurance

☐ Cancel coverage

Add or Reduce

New hire/Newly eligible enrollment $ _____ ($20,000 increments up to $100,000)

Additional requested amount above guaranteed issue** $ _____ ($20,000 increments up to $500,000)

Total requested amount $ _____ ($600,000 maximum)

Required: Tobacco use status, check one

☐ I have used tobacco products in the previous 12 months. (Tobacco premium rates apply.)
☐ I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

B: Spouse/Domestic Partner optional life insurance

☐ Cancel coverage

Add or Reduce

New hire/Newly eligible enrollment $ _____ ($20,000)

Additional requested amount above guaranteed issue** $ _____ ($20,000 increments up to $380,000)

Total requested amount $ _____ ($400,000 maximum)

Required: Tobacco use status, check one

☐ Spouse/domestic partner has used tobacco products in the previous 12 months. (Tobacco premium rates apply)
☐ Spouse/domestic partner has not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

C: Dependent life insurance

Provides $5,000 of coverage for each of your PEBB eligible dependent(s) (including spouse or domestic partner).
See rates at http://www.pebbinfo.com

☐ Cancel coverage

☐ Enroll in coverage

D. Accidental death & dismemberment (AD&D) insurance

☐ **Employee only** ☐ Cancel coverage

Total requested amount $_____ ($50,000 increments up to $500,000 maximum)

Medical history is not required.

Or

☐ **Employee and dependent optional AD&D** ☐ Cancel coverage

Total requested amount $_____ ($50,000 increments up to $500,000 maximum)

Medical history is not required.

E. Disability insurance

Monthly premium is calculated on a percentage of your basic monthly salary. Benefits may replace a portion of salary when the employee has a qualified disability claim.

Short term disability

Short term disability plans pay weekly benefits with coverage dates depending upon plan enrollment.

☐ Enroll in coverage ☐ Cancel coverage

Long term disability

Long term disability plans pay monthly benefits starting after 90 or 180 day waiting period depending upon plan enrollment.

☐ Enroll or change coverage ☐ Cancel coverage

- ☐ After 90 day plan pays 60%
- ☐ After 90 day plan pays 66-2/3%
- ☐ After 180 day plan pays 60%
- ☐ After 180 day plan pays 66-2/3%

F. Long term care insurance

To enroll for Long Term Care (LTC) insurance complete a Unum Enrollment Form at:
https://www.oregon.gov/OHA/PEBB/Pages/forms.aspx
For more information, please visit:
https://www.oregon.gov/oha/pebb/Pages/Long-Term-Care.aspx

Section 8: Beneficiary designation

I elect:

☐ The Standard Order of Survivorship. *(If you have a Domestic Partner, an Affidavit must be on file for distribution.)*

☐ To designate the following beneficiaries. *(Attach additional sheets if necessary.)*

Total of primary percentages must = 100% **Total of contingent percentages must = 100%**

Name			Address			
City	State	ZIP	Relationship	Primary or contingent ☐ OR ☐	Whole %	
Name			Address			
City	State	ZIP	Relationship	Primary or contingent ☐ OR ☐	Whole %	
Name			Address			
City	State	ZIP	Relationship	Primary or contingent ☐ OR ☐	Whole %	

Section 9: Employee signature and authorization

I declare the dependents listed and I are eligible for the coverages requested per Oregon Administrative Rule (OAR) Division 15. I have read the benefit materials, and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments to be deducted from my pay.

I understand that:

- The benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan.
- A person who knowingly makes a false statement in connection with an application for any benefit may be subject to penalty for false claims including, but not limited to: termination of enrollment, denial of future enrollment, civil damages, imprisonment and fines.
- If I fail to report a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.
- You must submit a midyear change form to your payroll office within 30 days of the date when an individual you provide coverage for is no longer PEBB eligible. If your notice is late, you and your qualified beneficiaries may lose the right to elect COBRA.
- This form supersedes all forms and submissions I have previously made regarding PEBB coverage for myself, and the individuals named above.

☐ I certify under penalty of Oregon State law that the information I have provided within this application is true and accurate to the best of my knowledge and belief.

Employee signature

Date

Submit this completed form to your agency/university payroll office.
Please keep a copy of benefit documents for your records.